KPMG Consulting

First Report to Congress on the Evaluation of The Department of Defense Federal Employees Health Benefits Program Demonstration Project

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Executive Summary

1. Background

The National Defense Authorization Act of 1999 (Public Law 105-261) required the Department of Defense (DoD) and the Office of Personnel Management (OPM) to establish a three-year demonstration that would allow Medicare-eligible DoD beneficiaries and their dependents to enroll in Federal Employees Health Benefits Program (FEHBP) plans in designated geographic areas. The objectives of the demonstration were:

- To test the feasibility of offering the FEHBP option to uniformed services retirees on a permanent basis, and
- To assess implementation processes and outcomes and analyze the projected impact if the FEHBP option were expanded to a national program.

The legislation was the result of concerns among uniformed services retirees and the organizations that represent them as well as Members of Congress that the health care options available to these retirees 65 years and older were insufficient to address their needs. Eligibility for TRICARE ends at age 65 when eligibility for Medicare begins. Although these retirees retain some rights to treatment at Military Treatment Facilities (MTFs) if one is located at a reasonable distance from where they live, they can receive care on a space-available basis only, and they are last on the priority list.

2. Overview

Under the Demonstration, uniformed services retirees eligible for Medicare Part A and specified family members are eligible to enroll in an FEHBP plan if they live in one of the eight designated demonstration sites. In the first year of the Demonstration, the following sites were designated in accordance with criteria specified in the law: Humboldt County, California; Greensboro-Winston-Salem, North Carolina; New Orleans, Louisiana; Puerto Rico; Camp Pendleton, California; Fort Knox, Kentucky; Dover, Delaware; and Dallas, Texas. The number of demonstration sites was expanded to ten in the second year with the addition of sites in Iowa and Georgia.

The first enrollment period ran from November 1999 to January 2000. Coverage for the Demonstration runs from January 1, 2000 through December 31, 2002. Enrollees' premiums are calculated in accordance with the statutory formula that applies to all FEHBP enrollees. DoD pays its contribution based on the same formula. Enrollees also pay cost sharing under the benefits provisions of the plan they elect. Participants in the Demonstration are ineligible for health care and pharmacy services through TRICARE or from MTFs for the duration of the Demonstration. The General Accounting Office (GAO) estimated that the cost to DoD of extending the FEHBP option to the eligible uniformed services retiree beneficiaries would be $1.6 billion per year or $1,571 per participant. The estimate was based on an 83 percent

participation rate. This first report by DoD and OPM to the Congress on the demonstration project responds to questions specified in the legislation.

3. *First Year Results*

To communicate information about the project to those eligible, DoD sent eligible beneficiaries several pieces of informational material including a specially designed enrollment guide, and sponsored a series of health fairs and town hall informational meetings in demonstration sites. They established a telephone center dedicated to answering questions about the project and providing additional materials upon request.

The enrollment results were far less than the original GAO estimate of 83 percent participation. Of approximately 69,000 eligible individuals in the initial eight demonstration sites, only about 2,500 beneficiaries (3.6 percent of all those eligible) enrolled during the initial enrollment period, which ran from November 1999 to January 2000.

4. *Evaluation of the Project*

The evaluation of the Demonstration began in the summer of 2000 and will continue through September 2002. The primary objective of the evaluation is to provide information and analyses of the impacts, feasibility, and potential for expanding the Demonstration program to a national permanent program. A key tool for the evaluation was a survey of eligible DoD beneficiaries who chose to enroll and chose not to enroll in FEHBP plans in 2000. In addition, some of the findings in this Report are based on DoD and OPM staff observations and informal health plan surveys. The initial evaluation results are incorporated into this report, the first of two that DoD and OPM jointly are required to submit to the Congress. The second report is due in December 2002.

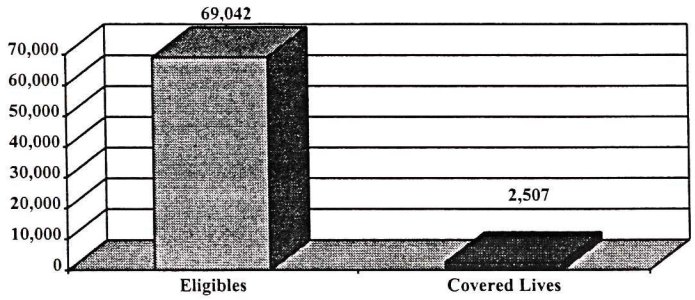
5. *Report Components*

This report answers the specific questions asked by the Congress and provides analysis based on information gathered through the evaluation.

A. NUMBER OF ELIGIBLE BENEFICIARIES WHO CHOSE THE FEHBP OPTION

After an extended enrollment period, the total enrollment in the FEHBP option during 2000 was 2,507 covered lives, including dependents in family enrollments.

Figure 1. The Number of Eligibles Compared to Covered Lives for 2000



Since the uniformed services retiree population was unfamiliar with the FEHB Program, DoD provided information and assistance beyond what is usually given to Federal retirees who participated in the Program during their years as active employees. Despite this expanded marketing effort, initial enrollment results were disappointing. The first open enrollment period began in November of 1999 and ran concurrent with the FEHB Program's normal Open Season period. Since initial enrollment was low, DoD extended the enrollment period for six additional weeks.

The survey was designed to identify reasons for enrolling and not enrolling in the Demonstration. Responses indicate that over half of the eligible population was not aware of the Demonstration project. Eligible retirees who were aware of the Demonstration and did not enroll said that they were:

- Unclear on how the benefits would work with Medicare,
- Worried about not being able to use MTFs or military pharmacies,
- Waiting to see how the program worked,
- Afraid to enroll in the Demonstration because it was only going to last for three years, and
- They feared that they would be uninsured when it ended.

Survey results for beneficiaries who enrolled, who were asked to indicate reasons for enrollment, show that:

- They needed better prescription drug coverage,
- They found an FEHBP plan with benefits that met their needs, and
- FEHBP coverage costs less than other options available to them.

Feedback from the Iowa Foundation for Medical Care, the vendor who handled enrollments for DoD, and participant responses at health fairs and town hall meetings indicate these additional factors:

- Beneficiaries were satisfied with other available options that they considered comprehensive and affordable, such as Medicare HMOs or care at MTFs; and
- Beneficiaries considered FEHBP plan costs, including premiums and cost sharing, too high compared to other available options.

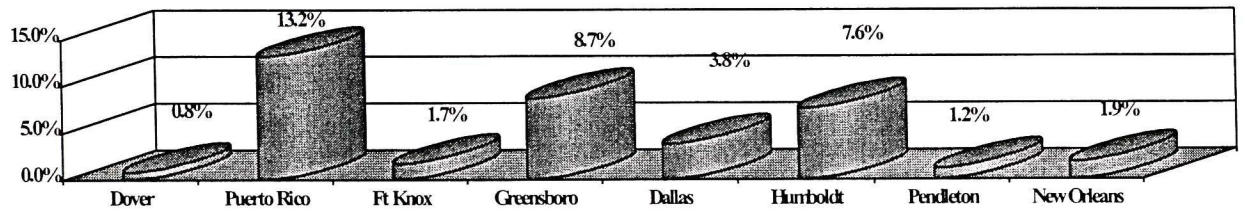
Based on these survey results and staff observations, it appears that the value of the FEHBP Plan option to beneficiaries varies with the availability of other options. Generally, in areas where other comprehensive and affordable coverage is available, the likelihood that beneficiaries will enroll in the FEHB Program is decreased. For example, beneficiaries who live close to military treatment facilities and receive free health care and free prescription drugs do not find an FEHBP health plan that requires them to pay about 25 percent of the premium valuable. Similarly, beneficiaries who live in an area served by a Medicare HMO with typically lower premiums than FEHBP plans do not find the FEHBP option attractive.

In some areas, the only available options are Medicare supplement policies, which cost significantly more than FEHBP coverage, but provide fewer benefits. In other areas, Medicare HMOs were never or are no longer available. In these areas, FEHBP coverage may be an attractive alternative.

B. PERCENTAGE OF ELIGIBLES WHO ENROLLED IN THE FEHBP OPTION (OVERALL AND BY DEMONSTRATION SITE)

Overall, 3.6 percent of eligible retirees enrolled in the FEHBP option in the first year. The percent that enrolled, however, varied from 13.2 percent in Puerto Rico to less than 1 percent in Dover, DE.

Figure 2. Percentage of Eligibles Enrolled by Site for 2000



- Areas without easy access to military treatment facilities (MTF) such as Greensboro, Dallas, and Humboldt enrolled a significantly higher percentage of eligibles than areas with MTFs.
- The one noted exception is Puerto Rico, which has the highest penetration rate of all sites. Although Puerto Rico is technically a catchment area of a military treatment facility, the commute to the facility is two hours for some beneficiaries. Puerto Rico is the only demonstration site without competing Medicare HMOs and only one Medicare supplement policy is offered.

EDUCATION AND MARKETING DURING 2000 FOR 2001

Due to the unfamiliarity of DoD beneficiaries with the FEHB Program and the lessons learned during the first open enrollment period, DoD started the marketing campaign earlier in the year 2000. The marketing materials and town hall presentations were revised to specifically address the concerns raised by beneficiaries during the first open enrollment period.

ENROLLMENT RESULTS FOR 2001 COMPARED TO 2000

In February of 2000, DoD added two additional sites to the Demonstration project. The addition of Adair, Iowa and Coffee, Georgia increased the number of eligibles in the demonstration from about 69,000 to approximately 129,000. Enrolled covered lives increased from 2,507 at the conclusion of the first open enrollment period to approximately 7,600 by the conclusion of the second. Although it appears that the increased marketing efforts had some effect on enrollment, the results are still minimal as a percentage of total eligibles. In 2000, approximately 3.6 percent of total eligibles enrolled. In 2001 the percentage increased only to 5.9 percent.

Figure 3. Total Eligibles Compared to Covered lives for 2000 and 2001

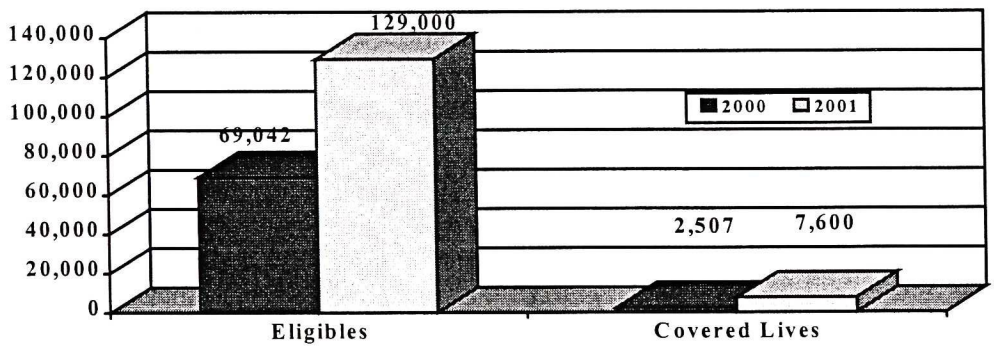
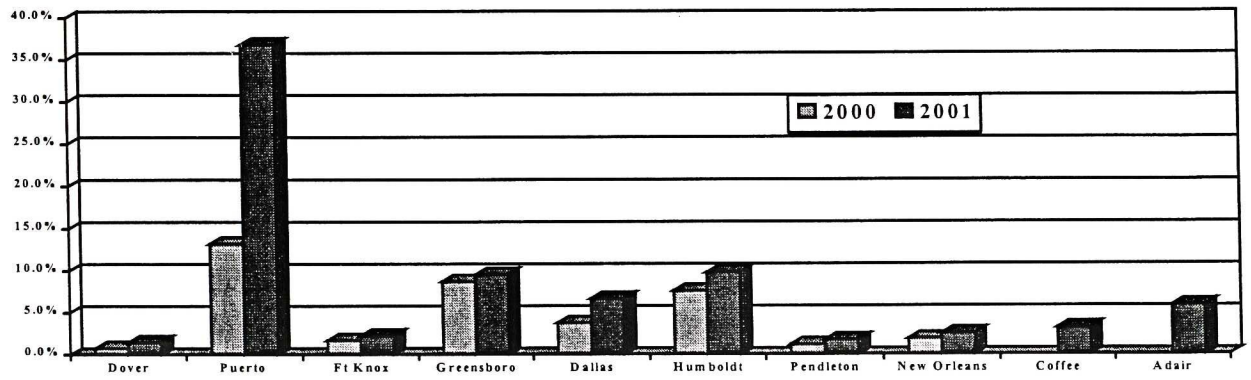


Figure 4. Percentage of Eligibles Enrolled by Site for 2001 Compared to 2000



- Increased marketing and educational efforts had minimal impact on enrollment in the original demonstration sites, except Puerto Rico. Most new enrollees came from Puerto Rico and the two new sites Coffee, Georgia and Adair, Iowa.

C. PERCENTAGE OF ELIGIBLES WITHOUT MEDICARE PART B

Over 90 percent of eligible retirees had Medicare Part B coverage during both 1999 and 2000. On average the proportion of beneficiaries who enrolled in the FEHB Program with Part B coverage exceeded those who did not enroll.

D. COSTS OF HEALTH SERVICES OF ENROLLED DoD BENEFICIARIES COMPARED TO OTHER FEHBP ENROLLEES

The following table shows the cost data collected by OPM. The costs are for DoD and FEHBP members with Medicare and are based on the weighted average of the following plans: Blue Cross High Option, Blue Cross Standard Option, GEHA and SSS Puerto Rico. These three FEHBP health plans comprise over 93 percent of Demonstration project enrollment.

Table 1. 2000 Claims Costs Per Member with Medicare*

Prescription Drug and Total Expenditures	DOD Member	FEHBP Member
Prescription Drug Expenditures	$1,075	$1,338
Total Expenditures**	$1,948	$2,795

* The above is based on 11 months of data projected for a 12-month period.
**Total expenditures include prescription drug expenditures and other medical expenditures.

Initially, DoD members' costs appear to be lower than FEHBP members' costs. We will continue to explore this cost difference and report any additional findings in the final report. These initial DoD cost data are preliminary and should not be relied upon to project the costs of a mature benefit program.

E. ACCESS TO CARE IN MTFs

Given the low enrollment rates during the initial year of the Demonstration, its effects on the accessibility of health care in military medical treatment facilities are minimal. Those who enrolled in the FEHBP Plan option in the first year were less likely than non-enrollees to have used MTFs for their health care prior to their enrollment. Therefore, the fact that they now receive care through the FEHBP did not significantly impact treatment priorities or accessibility of MTF services for other eligible uniformed services retirees.

F. IMPACT ON MILITARY READINESS AND TRAINING

The enrollment of some uniformed services retirees in the FEHB Program had little to no impact on military medical readiness or training in the first year of the program. If FEHB plans were to be available to uniformed services beneficiaries nationally and permanently, and more uniformed services retirees elect the option, there could be effects on medical military readiness, since fewer older patients would receive treatment at the facilities.

G. BUDGET IMPACTS

DoD/MTF

Converting the Demonstration into a permanent national program would have an uncertain impact on the DoD budget. Depending upon enrollment rates and MTF health care costs of enrollees, DoD annual costs could increase by as much as $108 million or decrease by up to $20 million.

OPM

For the first year of the Demonstration, OPM spent a total of $222,415 on the administration of the Demonstration project. This amount includes employee salaries and benefits, travel, and enrollment guide printing and distribution expenses.

Health Plans

When asked, health plans indicated that the administrative work that it took to set up and manage the Demonstration was enormous when weighed against the low enrollment rate. HMOs in particular find administering a program for Medicare enrollees outside of a risk contract very difficult and costly.

H. IMPACTS OF THE DEMONSTRATION ON COST AND ACCESSIBILITY OF PRESCRIPTION DRUGS

Based on information provided by OPM on first year prescription drug claims paid, we estimate that converting the Demonstration into a permanent national program could increase DoD annual costs for prescription drugs by between $49 million and $115 million. This variation reflects uncertainty concerning program enrollment rates. Also, these cost increases reflect an increase in access to prescription drug coverage through the Demonstration, especially for those enrollees without access to an MTF. In contrast, the relatively lower estimated total budgetary impacts are due to larger offsetting reductions in the costs of all DoD direct care provided.

I. ENROLLMENT FREQUENCY RECOMMENDATIONS

Public Law 105-261 requires that this report make certain recommendations on how many opportunities eligible beneficiaries should have to enroll in the FEHB Program should this become a permanent offering. The three options detailed by the legislation are whether eligible beneficiaries—

"1. should be given more than one chance to enroll in the demonstration project under this section;

2. should be eligible to enroll in the project only during the first year following the date that the eligible beneficiary becomes eligible to receive hospital insurance under part A of title XVIII of the Social Security Act; or

3. should be eligible to enroll in the project only during the 2-year period following the date on which the beneficiary first becomes eligible to enroll in the project."

We are in the process of evaluating these options and will make our recommendation in the *Second Report to Congress*.

J. OTHER FINDINGS

Based on feedback we received from DoD beneficiaries at health fairs and DoD's enrollment vendor staff at the conclusion of the first open enrollment period, we learned that DoD beneficiaries need more information earlier than would a typical FEHBP retiree. We discovered that there is a significant learning curve involved with educating the DoD population about a multi-option health benefit program like the FEHBP. Under TRICARE, beneficiaries do not review multiple health plan options annually or actively enroll in new health plans. They are enrolled in TRICARE when they enter the uniformed services and are not required to make any other enrollment decisions during their career, unless they move from one TRICARE Prime service area to another. A civilian Federal employee on the other hand must be enrolled in the FEHB Program for five or more years before qualifying to carry insurance coverage into retirement. Most employees under the FEHB Program have FEHBP coverage throughout their careers and may choose annually among at least 12 plan options. By the time they retire, they have learned the processes and procedures involved with participating in a multiple-option health benefits program.

Given the extensive need for education of DoD beneficiaries, should this program be made permanent, it must be marketed by an organization with experience in presenting multiple-option consumer choice health benefits programs. This organization should be available on an ongoing basis to provide customer service support to current enrollees and to educate and enroll new beneficiaries who age into the program. The entity should work closely with uniformed services retirement counselors and should perform all of the same functions that civil service personnel and payroll offices perform with regard to health benefits, such as enrollment, education, and counseling as well as premium collection and dissemination.

K. MITIGATING EVENTS

The National Defense Authorization Act for 2001 (Act) contains provisions that extend TRICARE pharmacy coverage to Medicare eligible retirees, spouses, and survivors effective April 1, 2001. The Act also allows these beneficiaries to regain eligibility for TRICARE medical benefits effective October 1, 2001. Beneficiaries will not pay premiums for these new "TRICARE-for-life" benefits.

To-date, the availability of alternative comprehensive and affordable health care options, such as Medicare HMOs and MTFs has significantly reduced demand for FEHBP coverage. Only 5.9 percent of those eligible have enrolled in FEHBP plans during the past two open enrollment periods. When fully implemented, the new "TRICARE-for-life" benefits will cover Medicare coinsurance and deductibles and prescription drugs very much like an FEHBP plan, without the

25 percent enrollee premium contribution required under the FEHB Program. Full implementation of these enhanced military health system benefits could further reduce demand for FEHBP health benefit coverage.

I. BACKGROUND AND DESCRIPTION OF THE FEHBP DEMONSTRATION PROGRAM

A. BACKGROUND AND OBJECTIVES OF THE DEMONSTRATION

The Department of Defense (DoD) and Federal Employees Health Benefits Program (FEHBP) Demonstration was developed to address concerns that health care options for uniformed services retirees aged 65 years and older were insufficient to address this population's health care needs. While uniformed services personnel enjoy a range of health care options under the TRICARE system, retirees generally are no longer eligible for TRICARE coverage when they turn 65 and become eligible for Medicare. Over-65 retirees who live near Military Treatment Facilities (MTFs) can receive care on a space-available basis, but are last in priority to receive health care. Recent changes in the uniformed services population have further reduced options available to over-65 uniformed services retirees and their dependents. These changes include a reduction of resources for active uniformed services personnel, most notably evidenced in the downsizing and closing of numerous military treatment facilities. Over the past ten years, medical personnel strength has been reduced by 15 percent, and one-third of all military hospitals have been closed.

FEHBP, with its wide selection of health plan options, was offered as a potential solution to the lack of available health care coverage for an older, higher-cost population. Initiated in the fall of 1999, the DoD FEHBP Demonstration permitted Medicare-eligible uniformed services retirees and their eligible dependents, in eight Demonstration sites, to choose to participate in the FEHBP.

Background

The DoD FEHBP Demonstration was established under the National Defense Authorization Act of 1999. The objectives of the three-year Demonstration, administered jointly by the DoD and the Office of Personnel Management (OPM) are:

- To test the feasibility of providing the FEHBP option to uniformed services retirees on a permanent basis; and
- To assess implementation processes and outcomes, and the impacts of the FEHBP option, under the Demonstration and projected to a national program, on the DoD budget, DoD prescription drug costs, medical readiness and training, and on access to care and services for uniformed services retirees and their dependents.

Under the Demonstration, Medicare-eligible retired uniformed service members and their dependents in designated demonstration sites are eligible to enroll in the FEHBP. Apart from residence in one of the eight DoD/FEHBP Demonstration sites, eligibility in the DoD/FEHBP Demonstration requires beneficiaries to be either an over-65 uniformed services retiree eligible for Medicare Part A; a family member of an eligible retiree; an un-remarried former spouse of a uniformed services member; or a family member of a deceased active or retired uniformed services member. The following eight sites were designated for inclusion in the Demonstration in

the first-year enrollment season: Humboldt County, California; Greensboro-Winston-Salem, North Carolina; New Orleans, Louisiana; Puerto Rico; Camp Pendleton, California; Fort Knox, Kentucky; Dover, Delaware; and Dallas, Texas. The number of demonstration sites was expanded to ten for the second year of the Demonstration with the addition of sites in Iowa and Georgia.

Of more than 69,000 eligible individuals in the initial eight demonstration sites, approximately 2,500 beneficiaries (3.6 percent of all those eligible) enrolled during the initial enrollment period, which ran from November 1999 to January 2000. Coverage for the Demonstration runs from January 1, 2000 through December 31, 2002. A series of health fairs and town hall informational meetings was held at each demonstration site, with DoD representatives available to answer questions and provide information.

Eligible retirees and their families who wish to participate in the Demonstration are required to pay applicable premiums for their health care coverage, with DoD contributing up to 75 percent toward enrollees' premiums. Those who elect to participate in the Demonstration are ineligible for health care and pharmacy services through TRICARE or MTFs for the duration of the Demonstration. The General Accounting Office (GAO) estimated that the cost of extending FEHBP to Medicare-eligible retirees, assuming 83 percent participation, would cost the DoD $1.6 billion per year or $1,571 per participant. Participants would pay about 25 percent of the plan premium, as well as copayments and deductibles, which varied across plan options.[1]

Objectives

The evaluation of the DoD FEHBP Demonstration began in the Summer of 2000 and is slated to continue through September 2002. The primary objectives of the evaluation are to provide information and analyses on the feasibility, impacts, and potential for expanding the Demonstration program to a national permanent program. This information and the analytic results provide the basis for the two *Reports to Congress* that DoD and OPM will jointly prepare and submit to Congress in April 2001 and in December 2002.

The key issues that Congress directed DoD and OPM to address in this *First Report to Congress* are:

A. Number of eligible beneficiaries who chose the FEHBP option, overall and by demonstration site;

B. Percentage of eligible beneficiaries who chose the FEHBP option, overall and by site;

C. Percentage of eligible beneficiaries who chose the FEHBP option and did not have Medicare Part B coverage;

D. Enrollment rates and costs of health services provided to uniformed services retirees electing the FEHBP option, compared to other similar FEHBP enrollees;

[1] Military Retirees' Health Care: Costs and Other Implications of Options to Enhance Older Retirees' Health Benefits. GAO/HEHS-97-134, June 20, 1997.

E. Impact of the FEHBP Demonstration on accessibility of health care in MTFs and unintended effects on treatment priorities in those facilities in the demonstration sites;

F. Implementation experiences, problems encountered, and their resolution;

G. Effects of the FEHBP Demonstration on medical readiness and training at MTFs in the demonstration sites and potential effects if the FEHBP option was extended to a permanent national program;

H. Effects on the budgets of DoD, OPM, and individual MTFs, if the FEHBP option was extended to a permanent national program;

I. Impacts of the FEHBP option on DoD costs for prescription drugs and on the accessibility, availability and cost of drugs to eligible beneficiaries;

J. Additional information that would be useful to Congress in determining the viability of expanding the FEHBP option to a permanent national program; and

K. Recommendations on how many opportunities beneficiaries should be given to enroll in the FEHBP.

This Report presents the results of the evaluation of the first year experience and impacts of the FEHBP Demonstration. In addition, this Report provides recommendations to Congress about future implementation and operations of the Demonstration.

B. Characteristics of Demonstration Sites and FEHBP Options Offered

Table 1 outlines the FEHBP options and other defining characteristics of the eight first-year sites in the Demonstration.

Table 1. Characteristics of FEHBP and Other Insurance Options Available, by Demonstration Site.

DoD/FEHBP Demonstration Site	FEHBP Options	Non-FEHBP Options for Over-65 Uniformed Services Retirees
Dover, DE	7 HMO Plans, 11 Fee-for service options, 1 Point-of-service Plan Available	Medicare Subvention Demonstration (TRICARE Senior Prime); 1 Medigap Plan, 3 Medicare HMOs
Fort Knox, KY	8 HMO Plans available in Kentucky; 15 HMOs available in Indiana; 11 Fee-for-service options available in Kentucky and Indiana; 1 Point-of-service Plan available in Kentucky	4 Medigap Plans, 9 Medicare HMOs
New Orleans, LA	1 HMO Plan, 11 Fee-for-service options, 2 Point-of-service options available	3 Medigap Plans, 9 Medicare HMOs available
Greensboro, North Carolina	6 HMO Plans, 1 Point-of-service Plan, 11 Fee-for-service options available	5 Medigap Plans Available
Humboldt County, CA	19 HMO Plans, 11 Fee-for-service options available	3 Medigap Plans, Over 16 Medicare HMOs available
Camp Pendleton, CA	11 HMO Plans, 11 Fee-for-service options	16 Medicare HMOs, 3 Medigap Plans available
Dallas, TX	4 HMO Plans, 11 Fee-for-service options	4 Medicare HMOs, 4 Medigap Plans available
Puerto Rico	1 Point-of-service, 11 Fee-for-service options	1 Medigap Plan available; No Medicare HMOs available

II. EVALUATION FINDINGS

This section reports the findings from the first year of the Demonstration evaluation. Particular attention is paid to addressing the specific research questions posed by the Congress.

A. NUMBER OF ELIGIBLE BENEFICIARIES WHO CHOSE THE FEHBP OPTION, OVERALL AND BY SITE

Of the approximately 69,000 uniformed services retirees and dependents who were eligible to enroll in the Demonstration during the 2000 open enrollment period, the largest eligible population concentrations were in the Camp Pendleton, CA and Dallas, TX demonstration sites, which accounted for over half of the total eligible population (Table 2).[2] These two sites, however, accounted for only about one third of the Demonstration enrollees. Instead, almost half of the Demonstration enrollees were located in the Puerto Rico demonstration site.

Table 2. Distribution of the FEHBP Eligible Population by Demonstration Enrollment Status, Overall and by Demonstration Site for 2000.

Enrollment into FEHBP	Eligible Non-Enrollees	Enrolled in the FEHBP	Total
Overall	66,535	2,507	69,042
By Site			
Dover, De	4,349	35	4,384
Puerto Rico	5,994	913	6,907
Fort Knox, KY	7,623	134	7,757
Greensboro/Winston Salem, NC	2,993	285	3,278
Dallas, Texas	13,087	520	13,607
Humboldt County, CA	2,698	221	2,919
Camp Pendleton, CA	24,804	303	25,107
New Orleans, LA	4,987	96	5,083

Source: Information provided by Iowa Foundation for Medical Care (IFMC).

B. PERCENTAGE OF ELIGIBLE BENEFICIARIES WHO CHOSE THE FEHBP OPTION, OVERALL AND BY SITE

Overall, 3.6 percent of the eligible population enrolled in an FEHBP plan (Table 3). There was considerable variation in the enrollment rates across demonstration sites, ranging from less than one percent (Dover) to over 13 percent (Puerto Rico). This variation could be due to a number of factors, including the effectiveness of the informational campaign, the availability of alternative sources of coverage, the costs of alternative plans relative to those of the FEHBP products, and

[2] Based on estimates at the time of the enrollee survey. More recent information indicates that the first-year eligible population may have been as high as 71,000 retirees and dependents.

satisfaction with existing coverage. In particular, the Puerto Rico site, with the highest enrollment rates, also has no Medicare HMO options and only one Medicare supplemental insurance option.

Table 3. Percentage Distribution of the FEHBP Eligible Population by Enrollment Status, Overall and by Demonstration Site for 2000.

Enrollment into FEHBP	Eligible Non-Enrollees	Enrolled in FEHBP
Overall	96.4	3.6
By Site		
Dover, De	99.2	0.8
Puerto Rico	86.8	13.2
Fort Knox, KY	98.3	1.7
Greensboro/Winston Salem, NC	91.3	8.7
Dallas, TX	96.2	3.8
Humboldt County, CA	92.4	7.6
Camp Pendleton, CA	98.8	1.2
New Orleans, LA	98.1	1.9

Source: Information provided by Iowa Foundation for Medical Care (IFMC).

C. Percentage of Eligible Beneficiaries Who Chose the FEHBP Option and Did Not Have Medicare Part B Coverage

Almost all eligible retirees had Medicare Part B coverage during both 1999 and 2000 (Table 4). On average, the proportion of FEHBP enrollees with Part B coverage exceeds that of non-enrollees by between two and three percentage points.

Table 4. Percentage of the Eligible Population with Medicare Part B Coverage by Enrollment Status, by Demonstration Sites, 1999 and 2000.

Demonstration Site	Medicare Part B in 1999		Medicare Part B in 2000	
	Enrolled in DoD FEHBP	Not Enrolled in DoD FEHBP	Enrolled in DoD FEHBP	Not Enrolled in DoD FEHBP
Overall	93.5	91.5	94.3	91.8
By Site				
Dover, De	90.0	95.3	90.0	95.3
Puerto Rico	92.6	79.3	93.1	79.3
Fort Knox, KY	92.9	93.2	93.8	93.2
Greensboro/Winston Salem, NC	96.7	92.9	97.4	94.2
Dallas, TX	91.9	91.3	93.2	91.6
Humboldt County, CA	97.2	96.0	97.2	96.0
Camp Pendleton, CA	94.2	91.7	95.6	92.0
New Orleans, LA	90.0	96.3	90.0	96.3

Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care". Information on Medicare Part B provided by the General Accounting Office (GAO).

D. Analysis of the Costs of Health Services Provided to Uniformed Services Retirees Electing the FEHBP Option, Compared to Other Similar FEHBP Enrollees

Table 5 shows the cost data collected by OPM. The costs are for DoD and FEHBP members with Medicare and are based on the weighted average of the following plans: Blue Cross High Option, Blue Cross Standard Option, GEHA and SSS Puerto Rico. These three FEHBP health plans comprise over 93 percent of the Demonstration enrollment.

Table 5. 2000 Claims Costs Per Member with Medicare.*

Prescription Drug and Total Expenditures	DoD Member	FEHBP Member
Prescription Drug Expenditures	$1,075	$1,338
Total Expenditures**	$1,948	$2,795

* The above is based on 11 months of data projected for a 12 month period.
**Total expenditures include prescription drug expenditures and other medical expenditures.

Initially, DoD members' costs appear to be lower than FEHBP members' costs. We will continue to explore this cost difference and report any additional findings in the final report. These initial DoD cost data are preliminary and should not be relied upon to project the costs of a mature benefit program.

E. Analysis of Impacts of the FEHBP Demonstration on Access to Care and Treatment Priorities in MTFs

Overall, we have found that the FEHBP Demonstration did not affect access to care or changes in treatment priorities in demonstration sites with MTFs in the first year of the Demonstration. The reasons for these conclusions are discussed in this section.

Background: Access To Care In Demonstration Sites

Health care at MTFs is delivered to those eligible for services according to the following priority system:[3]

1. Active duty service members.
2. Active duty family members who are enrolled in TRICARE Prime and survivors of uniformed services sponsors who died on active duty and were enrolled in TRICARE Prime.
3. Retirees, their family members and survivors who are enrolled in TRICARE Prime.
4. Family members of active duty service members who are not enrolled in TRICARE Prime and survivors of uniformed services sponsors who died on active duty and were not enrolled in TRICARE Prime.
5. All other eligible persons.

Retirees and their family members have lower priority for treatment because of their non-active duty status, and are therefore treated in MTFs on a space-available basis. Regardless of their priority for health care services, those who enroll in the FEHBP Demonstration and stop receiving care in the military health system still might affect MTFs. For example, fewer retirees will be eligible for services in MTFs as a consequence of their participation in the FEHBP Demonstration. Therefore, this could potentially increase access to services for individuals who do not enroll in, or who are not eligible for, the FEHBP Demonstration.

MTFs are available in four of the eight demonstration sites: Dover, DE; Puerto Rico; Fort Knox, KY; and Camp Pendleton, CA. The percent of the eligible population that received at least some of their health care in an MTF in 1999 is shown in Table 6. As expected, more program eligibles in sites with MTFs received at least some of their health care in an MTF than did those in non-MTF sites. In all sites except Puerto Rico, more non-enrollees than enrollees reported getting at least some of their care in an MTF in 1999. In Puerto Rico, slightly more FEHBP Demonstration enrollees than non-enrollees reported using an MTF in 1999.

[3] It should be noted that FEHBP Demonstration enrollees are no longer eligible to receive services from MTFs.

Table 6. Percent of the Eligible Population who used MTFs in 1999, by Enrollment Status, by Demonstration Sites.

Demonstration Site	Enrolled in DoD FEHBP	Not Enrolled in DoD FEHBP
Overall	9.8	17.3
By Site		
Dover, De	18.2	35.5
Puerto Rico	17.1	16.3
Fort Knox, KY	13.8	17.8
Greensboro/Winston Salem, NC	0.4	6.9
Dallas, TX	2.7	4.9
Humboldt County, CA	7.9	18.8
Camp Pendleton, CA	10.4	20.6
New Orleans, LA	2.2	8.5

Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

Table 7 reports the proportion of the eligible population in demonstration sites with MTFs who agreed or strongly agreed with the statement that they were able to get care in MTFs when they needed it. Those who enrolled in the FEHBP Demonstration program were less likely to agree with this statement than were those who chose not to enroll. However, only about half of the non-enrollees agreed that they were able to get care when they needed it, suggesting that the accessibility of health care is only part of the reason for enrolling.

Table 7. Percent of the Eligible Population in MTF Demonstration Sites Who Agreed or Strongly Agreed with the Statement That They Were Able to Get Care in the MTFs When Needed in 1999, by Enrollment Status, by Demonstration Sites.*

Demonstration Site	Enrolled in DoD FEHBP	Not Enrolled in DoD FEHBP
Overall	40.0	50.5
By Site		
Dover, DE	44.4	54.8
Puerto Rico	49.4	57.5
Fort Knox, KY	28.7	48.2
Camp Pendleton, CA	14.9	48.8

*Analysis excludes those who reported that they did not need health care and those who reported that they did not try to seek health care in the MTF.

Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

Table 8 shows that many of those program eligibles in demonstration sites with MTFs had difficulty scheduling appointments. More than half of the FEHBP enrollees in these four sites

experienced such difficulty. Of those who chose not to enroll in the FEHBP Demonstration, 45.1 percent overall found it difficult to schedule appointments. Given that such high numbers of non-enrollees had trouble scheduling appointments and still chose not to enroll, we can assume that access to care is only part of the reason for enrolling in the Demonstration.

Table 8. Percent of the Eligible Population in MTF Demonstration Sites Who Agreed or Strongly Agreed with the Statement That It was Difficult to Schedule Appointments in the MTFs in 1999, by Enrollment Status, by Demonstration Sites.*

Demonstration Site	Enrolled in DoD FEHBP	Not Enrolled in DoD FEHBP
Overall	54.3	45.1
By Site		
Dover, DE	62.4	47.1
Puerto Rico	50.5	41.6
Fort Knox, KY	72.7	52.1
Camp Pendleton, CA	58.1	42.9

*Analysis excludes those who reported that they did not try to schedule an appointment.
Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

Site-Specific Findings

Camp Pendleton

Overall, administrators at Camp Pendleton did not report any difference in access to care or treatment priorities as a result of the FEHBP Demonstration. This finding likely stems from the relatively small number of program eligibles that enrolled in the FEHBP at this site. However, should enrollment numbers rise significantly, there exists the potential to affect site operations.

In general, Camp Pendleton welcomes retirees into their MTF. Administrators report that they have never turned retirees away. As retirees near their 65th birthday, retirees receive a letter from the TRICARE contractor stating that they are no longer eligible for benefits. Camp Pendleton administrators market to this population by telling them that they could still receive health care at the MTF. As part of its family practice training program, Camp Pendleton provides primary care for retirees and other FEHBP eligibles. Camp Pendleton will provide specialty care for uniformed services retirees secondarily to active duty personnel. Most specialty care is provided to those who need it. Specialty care is provided either at the Camp Pendleton MTF or at Naval Medical Center, San Diego (Balboa Hospital).

Camp Pendleton is well within the established standards for scheduling appointments. Most routine appointments are scheduled within seven days. Wellness appointments are scheduled within 2.5 weeks (compared to the 28 day standard).

The staff at Camp Pendleton has not encountered any impact of the FEHBP Demonstration program on access to care or treatment priorities. The MTF administration has not received any

complaints from retirees about scheduling appointments. The Customer Relations Officer has not directly addressed or heard of any retiree experiencing a problem accessing care. In addition, the Health Benefits Advisor (who also serves as the Debt Collection Assistance Officer) has not addressed any problematic claims related to the FEHBP Demonstration. Treatment priorities remained the same after the implementation of the FEHBP Demonstration.

Despite the lack of complaints to Camp Pendleton administration, FEHBP eligibles reported significant problems with accessing care. Only 14.9 percent of enrollees, and 48.8 percent of non-enrollees agreed or strongly agreed that they were able to get care in MTFs when they needed it. More than 58 percent of enrollees and 42.9 percent of non-enrollees agreed or strongly agreed that it was difficult to schedule appointments.

Staff at Camp Pendleton stated that the scheduling of routine, non-life threatening appointments remains the weakest point in accessing care. Space-available policies dictate that patients are served on a first come-first served basis. When a patient urgently needs specialty care, other patients may get "bumped" to accommodate the patient in need of urgent care. However, the bumped appointment is always rescheduled.

Ft. Knox, Kentucky

Administrators at Fort Knox did not notice any impacts on access to care or in treatment priorities as a result of the FEHBP Demonstration. This finding is consistent with the relatively small number of eligibles that enrolled in FEHBP at this site. As in Camp Pendleton, however, should enrollment numbers rise significantly, there exists the potential to affect site operations.

Ireland Army Community Hospital has instituted space-available policies in which health care appointments from 9:00 am to 11:00 am are reserved for active duty uniformed services. After that time, appointments open up for others with lower priority for health care, including uniformed services retirees and dependents. The largest business of the hospital consists of delivering primary care. However, there is little capacity to treat anyone other than those enrollees in TRICARE Prime under their space-available policies.

Administrators at the MTF discussed the difficulty of scheduling appointments, with Monday as the busiest day and appointment availability for primary care opening up during the middle of the week. In an attempt to address this lack of availability of care for those with lower priority for care, the internal medicine clinic is attempting to schedule and treat some of their space-available patients as they would those covered under TRICARE Prime. Such accommodation is limited. If a retiree has not been seen at least twice in the last two years, they are referred to the TRICARE Service Center for a referral to a network provider. According to Ft. Knox administrators, the hospital's resources would be "greatly taxed" if this selective referral process (for those not covered under TRICARE Prime) was not employed. Since the emphasis of the hospital is on providing primary care, some specialty care is provided in the community. Access to specialty care is coordinated through the TRICARE Service Center.

The Health Benefits Advisor (also known as the Beneficiary Counselor and Assistance Coordinator) has not encountered problematic claims related to the implementation of the FEHBP. In addition, the Patient Advocate has not encountered any access-related concerns as a

result of the Demonstration. According to Ft. Knox administrators, treatment priorities remained the same after the implementation of the FEHBP Demonstration program.

Despite the lack of complaints to administrators, difficulty in getting care at this facility is apparent to FEHB Program eligibles. Only 28.7 percent of enrollees (compared to 48.2 percent of non-enrollees) agreed or strongly agreed that they were able to get care at military health facilities when they needed it. In addition, 72.7 percent of enrollees and 52.1 percent of non-enrollees agreed or strongly agreed that it was difficult to schedule appointments at military health facilities in 1999.

F. Assessment of Demonstration Implementation and Management Effectiveness

Implementation and Marketing Campaign

The DoD and OPM had mixed results in managing the marketing and implementation of the FEHBP Demonstration. Overall, program staff judged the implementation and enrollment of the FEHBP Demonstration to be successful. However, program staff reported that the marketing campaign to inform eligibles of the Demonstration suffered initially, since this set of beneficiaries requires a greater educational effort than do typical FEHBP retirees. As the marketing campaign continued, however, DoD and OPM representatives realized greater success in broadcasting the Demonstration to eligibles as a result of adjusting their marketing and informational strategy.

Description of Information Campaign and Marketing

The DoD designed one marketing plan for all of the FEHBP Demonstration sites. This plan describes the objectives and methods of the marketing activities. The objectives of the marketing plan are to:

- Inform the program eligibles and selected others of the FEHBP Demonstration,
- Educate the Demonstration eligibles about the FEHBP, and
- Educate program eligibles about the difference between the FEHBP and the military health system.

The first-year marketing campaign consisted of educational activities including a direct mailing of materials to program eligibles and participation in civilian FEHBP health fairs if they were held in the FEHBP Demonstration area. If no health fairs were held, the DoD held meetings to present information to program eligibles. The central messages of the marketing campaign included the following points:

- The program offers the opportunity for program eligibles to receive comprehensive health care from an array of FEHBP plans,
- The program offers program eligibles the opportunity to receive the same health care coverage as civilian federal employees,

- Program enrollees will be locked out of the Military Health System during their period of participation in the demonstration program,
- Certain program eligibles do not need Medicare eligibility to qualify for benefits;
- Enrollees must pay premiums, and
- The amount of the DoD contribution would not exceed the amount covered for Federal civilian employees.

In addition, the marketing campaign announced the dates of the initial open and subsequent open enrollment periods and the period of coverage.

Materials

As defined under a Memorandum of Understanding between DoD and OPM, both agencies had joint responsibility for developing educational and enrollment materials. However, in large part DoD assumed the lead in carrying out these activities. A postcard introducing the plan was the first piece mailed, and served as an address verifier. The "2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project" compared participating health plan premium rates and contained general benefit information and some customer satisfaction results. Other materials included individual plan benefit brochures and a cover letter, and a piece on the coordination of FEHBP and Medicare benefits. The tri-fold brochure produced for this Demonstration program was the centerpiece of the program's marketing and beneficiary education effort. Two versions of the tri-fold were developed. One version was in English and printed in black and white. The second version was translated into Spanish and was printed in color. A fact sheet with frequently asked questions was distributed as well. Finally, a letter describing the enrollment period extension and the retroactive payment process for those who chose to enroll during the extension was mailed to enrollees in December of 1999.

Health Fairs/Town Hall Meetings

The original marketing plan called for DoD to participate in FEHBP health fairs in the Demonstration sites during the open enrollment period. Where practical, these health fairs were held in conjunction or coordinated with other civilian FEHBP health fairs in the area. The health fair participation consisted of staffing a table along with other participating health plans. DoD and the Iowa Foundation for Medical Care (IFMC) staff, a subcontractor to DoD for marketing and enrollment activities, answered questions and distributed materials about the Demonstration. In sites without health fairs, DoD arranged for a presentation to program eligibles.

Other Marketing Efforts

The tri-fold contained toll-free phone numbers and website addresses for further information about the Demonstration. Both DoD and IFMC staff staffed the call center. The websites provided links to the OPM and DoD web pages for the FEHBP Demonstration.

Some additional marketing activities emerged that had not been originally planned. The local VFW in Redding, CA at the Humboldt County demonstration site was favorably predisposed towards the FEHBP Demonstration. Since no health fair had been planned for this area, the VFW

mounted a media campaign consisting of radio, television and newspaper coverage of the Demonstration staff's site visit and presentation. The Demonstration staff was unaware that any news coverage activities had been planned for the town hall meeting. In the North Carolina demonstration site a local newspaper carried an article about the Demonstration, and the U.S. Congressman from this district also provided information. While the Demonstration staff did not arrange for any media coverage, they welcomed the additional help in getting the word out. However, information presented by the local media was sometimes inaccurate. Finally, those responsible for marketing were aware of substantial positive word-of-mouth marketing about the Demonstration program.

Findings: Overall and By Site

The Demonstration staff found that there was a substantial difference between educating a new federal hire and educating a uniformed services retiree about FEHBP. Most program eligibles had never heard of FEHBP or of open enrollment. Also, program eligibles did not understand Medigap, or how HMOs or fee-for-service health insurance works. While IFMC was somewhat prepared for this, they were still surprised at the program eligibles' lack of knowledge.

DoD and IFMC substantially adjusted their educational methods to meet the apparent educational needs of retirees. Health fairs were not effective educational tools. First, the Demonstration staff was not welcomed at some health fairs and received a "hostile" reception. The organizers of the health fairs were concerned that the large pool of eligibles for the FEHBP Demonstration would overwhelm the health fair. In addition, the retirees had so many questions that a one-on-one question-and-answer format was not an effective method of disseminating information. For example, at the Ft. Knox, KY demonstration site, Demonstration staff was greeted with a line of people waiting for information. Realizing that they were not going to be able to answer all of the questions on an individual basis, the Demonstration staff arranged for a classroom and presented information in a "town hall" meeting format.

The newly conceived town hall meetings hosted by the Demonstration staff usually took the form of an hour-long presentation followed by an hour-long question-and-answer session. Some interview respondents noted that certain presentation styles enhanced their ability to present information effectively. These included speaking in an extemporaneous style with using visual aids, identifying with the audience as a uniformed services retiree, and addressing directly the issue of the "broken promise" of providing health care for life, even though "the broken promise" was not the subject of the educational session.

In addition to the educational sessions, program eligibles needed individual questions answered and, in some cases, counseling about the best choices for their particular situations. Demonstration staff was able to answer most questions. They were not able to advise program eligibles about which plan to choose, and instead referred eligibles to the health plans or to their state's Senior Health Insurance Information Program (SHIIP) for specific benefit information.[4]

[4] The SHIIP program provides advice to seniors on their health care choices. At the time of the first open enrollment, the FEHBP Demonstration staff did not have any contact with the state SHIIPs. For the 2000 open season, communications with the SHIIPs in the Demonstration states had been established.

Enrollment during the 1999 open season started off slowly. At the close of open season only 700-800 had enrolled. As a result of these low levels of enrollment, the open enrollment period was extended. A letter went out in December 1999 to beneficiaries stating that the open season was being extended, although applicants would be responsible for payment of premiums beginning January 1, 2000. IFMC ran additional town hall meetings and this helped increase enrollment.

Description of Implementation/Enrollment

The IFMC coordinated first-year enrollment activities, including fee collection and some enrollment processing. The application for enrollment was a simplified version of the standard OPM four-page application form, and was mailed out with the plan brochures. The application included a payment form for billing options and a return address envelope with a separate post office box number. Applicants were instructed to mail their applications to IFMC, who processed them and forwarded them on to the health plans selected by the enrollees. The IFMC worked individually with applicants to resolve any problems. Ineligible applicants were called and sent a personal letter to explain the problem. In these situations, IFMC helped facilitate the appeals process or corrected information, and worked with applicants on enrollment and payment. Enrollees received a letter after the health plan had processed applications. Applications had a two-day turn-around time in IFMC, and applicants were enrolled in one week. The IFMC tried to resolve all problems within two weeks.

In general, the application process worked smoothly. Most of the incomplete or problematic applications were in the Puerto Rico demonstration site. The DEERS file was unable to accommodate program eligibles who used their family names differently in different settings, which was more common in Puerto Rico than in other sites. In addition, getting the correct mailing addresses was a problem in Puerto Rico, because of inconsistencies in recording mailing and street addresses. The IFMC brought enrollment forms with them to the January, 2000 town hall meetings, and this helped to correct errors or resolve other application problems.

Awareness of the FEHBP Option

Survey results indicate that only 44.3 percent of the non-enrolled eligible population was aware of the Demonstration program. In six of seven sites, between 43 percent and 56 percent of the eligibles knew of the Demonstration program; however, in Puerto Rico a substantially smaller proportion of eligibles were aware of the Demonstration (Table 9).

Table 9. Percent of the Non-enrolled Who Knew of the FEHBP Demonstration.

Site	Percent
Dover, DE	47.2
Ft. Knox, KY	44.2
Puerto Rico	28.4
Camp Pendleton, CA	45.6
Greensboro, NC	55.5
Dallas, TX	42.8
Humboldt, CA	50.3
New Orleans, LA	49.2

Source: Analysis of the "Health Care Survey of Medicare Eligible. Military Retirees and Others Eligible for Military Health Care".

More than 70 percent of the enrolled population was aware of several features of the FEHBP Demonstration program. These features included the Government's contribution to the premium, the premium payment mechanisms, that enrollees cannot use MTFs, and that FEHBP members can leave the Demonstration at any time. In contrast, about half of the non-enrolled population was aware of these features (Table 10).

Table 10. Percent Reporting Knowledge of Specific Program Features.*

Knew that:	Percentage of enrolled	Percentage of non-enrolled
Government pays half of the premium	79.9	47.8
The premium is withheld from the retirement check	72.0	40.9
Physicians at MTFs can't treat enrollees	77.3	48.4
Enrollees can't use MTF pharmacies	78.4	52.4
FEHBP members can leave anytime	81.4	46.3

*Analysis excludes those without knowledge of the FEHBP option.
Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

The enrolled population consistently was more aware of FEHBP Demonstration features than were non-enrollees. More enrollees in Puerto Rico than in the other Demonstration sites knew that the premium is withheld from the retirement check. In contrast, enrollees in sites other than Puerto Rico were more aware that they were unable to use MTF physicians and pharmacies, that the government pays most of the premium, and that an FEHBP enrollee can leave the plan at any time than were enrollees in Puerto Rico (Table 11).

Table 11. Percentage of Enrollees and Non-enrollees Who Knew Specific Program Features.*

Demonstration Site	Government pays most of the premium	Premium payment usually withheld	Enrollees can't use MHS MDs	Enrollees can't use MHS pharmacies	Can leave anytime
Enrollees					
Dover	83.3	66.7	90.0	90.0	96.7
Puerto Rico	68.3	78.1	60.2	62.0	65.6
Fort Knox	86.5	69.6	87.9	88.8	84.3
Camp Pendleton	91.3	74.3	84.2	86.4	89.2
Greensboro	83.7	60.8	81.6	87.0	89.0
Dallas	80.9	70.9	84.6	83.7	86.7
Humboldt	84.2	67.6	87.2	87.2	90.7
New Orleans	93.5	73.9	88.3	80.8	93.4
Non-Enrollees					
Dover	52.5	39.1	62.9	68.5	53.6
Puerto Rico	43.3	43.9	39.9	41.1	37.1
Fort Knox	45.6	44.1	46.8	52.8	42.1
Camp Pendleton	51.0	39.8	48.0	52.8	45.4
Greensboro	49.4	55.4	52.5	53.7	57.4
Dallas	40.8	34.1	46.0	47.4	48.8
Humboldt	45.3	46.6	61.5	67.4	49.0
New Orleans	51.8	44.9	40.8	46.7	40.6

*Analysis excludes those without knowledge of the FEHBP option.
Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

Sources of Knowledge of the FEHBP Option

The results presented in this section pertain only to those who knew that they could enroll in an FEHBP plan.

Most of the program eligibles, 78.1 percent of the enrollees and 82.1 percent of the non-enrollees, learned about the FEHBP Demonstration from the information mailed to them. Other important sources of information were organizations that represent uniformed services retirees and their families, with 43.3 percent of the enrollees and 32.3 percent of the non-enrollees receiving information from these organizations.

Health fairs served an important educational role, particularly for enrollees. More than 25 percent of enrollees indicated that they learned about the Demonstration through their attendance at a health fair. In contrast, only 4.3 percent of non-enrollees learned about the Demonstration in this manner. About 37 percent of the enrollees and 32 percent of non-enrollees indicated that they received a brochure or information from one of the health plans. However, since health

plans were not allowed to market directly to eligibles, respondents might have not realized the source of the information that they received.

Most of the enrollees reported receiving the informational materials. Of those who knew of the Demonstration, more than 89 percent of enrollees reported receiving the postcard, 93 percent received the 2000 Guide to FEHBP plans, 89.3 percent received the brochure, and 88.4 percent received the FAQ. Fewer non-enrollees reported receiving materials. While 93.2 percent of non-enrollees reported receiving the postcard, 81.1 percent reported receiving the 2000 Guide, 74.1 percent received the brochure, and 65.9 percent received the FAQ.

Of those who knew that they could join an FEHBP plan, more enrollees than non-enrollees found the printed materials useful (Table 12). The Guide was ranked useful by the highest percent of those enrollees who reported receiving the materials. The postcard was ranked "useful" by the highest percent of non-enrollees who received the materials.

Table 12. Percentage of Respondents Ranking Materials as "Useful".*

Material	Enrollees	Non-enrollees
Postcard	88.2	63.7
2000 Guide	92.1	59.1
Brochure	90.8	55.7
FAQ	89.6	53.1

*Analysis excludes those without knowledge of the FEHBP option.
Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

Almost 77 percent of enrollees who knew of the Demonstration called the toll-free number for information, while only 13.1 percent of the non-enrollees did so. Of those who called the toll-free number, 72.1 percent of enrollees and 58.8 percent of non-enrollees did not have a problem getting the information they needed. Site-specific data reflected these patterns. Non-enrollees in sites without an MTF tended to use the toll-free number for information more than non-enrollees in sites with an MTF, suggesting more interest in the FEHBP in areas where military health care services were more limited.

Of those survey respondents who know that they were eligible to join an FEHBP plan, enrollees were more likely than non-enrollees to think that specific plan materials were clearer and that information provided to them was adequate. Enrollees and non-enrollees had different experiences in getting information about specific FEHBP plans. More than 75 percent of enrollees and almost 60 percent of non-enrollees indicated that they used the 2000 Guide for specific health plan information. Enrollees also relied heavily on calling plans (27.2 percent), reading their brochures (46.4 percent) and attending health fairs (35.2 percent). Non-enrollees received specific plan information from the 2000 Guide (59.7 percent) and from reading specific plan brochures (26 percent). More than 24 percent of non-enrollees indicated that they did not get any information at all, compared to only 1.2 percent of enrollees. Enrollees were more likely

than non-enrollees to indicate that plans' brochures were clear (56.9 percent versus 26.5 percent, respectively).

Both enrollees and non-enrollees (26.7 percent and 58.7 percent respectively) had trouble deciding whether to enroll. Both groups cited uncertainty about plan costs, although this was a more important reason for non-enrollees. Other factors that caused difficulty included uncertainty about how plans would work with Medicare, difficulty in understanding services, difficulty in comparing plans, and difficulty in determining whether FEHBP was better than what respondents currently had (Table 13).

Table 13. Percentage of Respondents Reporting Specific Reasons for Having Trouble Deciding Whether to Enroll.*

Reason	Enrollees	Non-enrollees
Wasn't sure how much the plan would cost me	57.6	72.5
Too many plans to choose from	16.2	14.7
Couldn't tell how plans would work with Medicare	58.4	54.4
No one to help me make a decision	20.4	25.2
Hard to understand what services were covered	44.6	33.0
Hard to compare all DoD FEHBP plans	43.6	30.8
Hard to compare DoD FEHBP plans with other plans I could buy	21.9	23.5
Hard to tell if DoD FEHBP plans were better than current insurance	53.9	72.3

*Analysis excludes those without knowledge of the FEHBP option and those without trouble deciding whether to join an FEHBP health plan.
Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

Other Implementation and Demonstration Management Issues

The management and implementation of the FEHBP Demonstration had both strong and weak elements. The greatest strength is the commitment within DoD, OPM, and the IFMC to design and implement a program that is effective in meeting the needs of the target population. The agencies cooperated effectively. The IFMC has a long history of working with DoD and has an excellent relationship with them. This commitment is further manifested in DoD's commitment to the program regarding both adequate funding and flexibility to adapt methods to better meet their constituents' needs. The implementation and marketing efforts were well managed and executed. Many people working on this program went far beyond what was expected of them. One result of this effort and cooperation was that the first year of a new program worked

relatively smoothly. Another result was that the program staff reported that they were perceived as helpful, caring and dedicated by program eligibles.

There were, however, some unsuccessful implementation and marketing elements. Specifically, the timetable was too compressed, particularly before the deadline was extended. The health fairs were held in November during open season, and open enrollment ended initially in December. Program eligibles informed Demonstration staff that this was not enough time for them to digest the information about multiple plans and make a decision.

Further, the letter announcing the deadline extension explained that applicants would be responsible for paying premiums retroactively back to January 1, 2000. While this rule is an FEHBP regulation, it caused some concern among retirees. Some retirees paid for being insured by two carriers simultaneously. The particular problem was the overlap with Medigap, which collects premiums on a quarterly, semiannual, or annual basis.

Another problem was the lack of training that the health plans provided to their staff on the FEHBP Demonstration. In many instances, the phone representatives at the health plan did not always know about the FEHBP Demonstration program. Program staff was concerned about the lack of credibility that might have been communicated to eligibles. They expressed the concern that the lack of credibility might affect buy-in.

Finally, the program staff also expressed the need for consistent, clear marketing materials that are available in a variety of forms. The marketing strategies should be tailored to meet the needs of the target population. Hard copy is especially important, and care should be taken to make sure that recipients open mailings. One mailing which contained the Frequently Asked Questions and an announcement of town hall meetings was mailed in a plain white envelope without a return address. Eligibles reported to program staff that they thought it was junk mail, and they reported that they threw it away. Other program eligibles reported to the IFMC that they receive such a large volume of mail from DoD and sometimes do not read all of it. Other technology should be used as well, including interactive web sites and videotapes.

G. Impacts on Military Medical Readiness and Training

The evaluation of the MTFs in the FEHBP Demonstration sites found that the Demonstration had no significant impact on military readiness and training at the MTFs. In the first year of the Demonstration, there were no indications that the Demonstration impacted the ability of any of the MTFs to perform their respective missions.

There are four FEHBP Demonstration sites that include an MTF. The Fort Knox, Kentucky demonstration site includes the Ireland Army Community Hospital at Fort Knox; the Camp Pendleton, California site includes the Camp Pendleton Naval Hospital; the Dover, Delaware demonstration site includes an MTF that is a medical clinic (436th Medical Group Clinic); the Commonwealth of Puerto Rico Demonstration site includes the Naval Hospital at Roosevelt Roads. These MTFs are configured to perform a mission appropriate to their area of assignment and the population served. Simply put, the larger military installations have larger MTFs. For example, Fort Knox, as the U.S. Army Armor Center and School is primarily a training center for Army Officers, Non-Commissioned Officers, and enlisted members. The Fort Knox military

population (i.e., active duty members, family members, and reservists) is approximately 104,000. Camp Pendleton is home to the 1st Marine Expeditionary Force, the 1st Marine Division, the 1st Force Service Support Group, and the 3rd Marine Aircraft Wing. The Camp Pendleton military population is 84,000. Dover Air Force Base houses the 436th Airlift Wing and the 512th Airlift Wing (a reserve unit). The Dover Air Force Base military population is approximately 8,000. The Naval Hospital at Roosevelt Roads in Puerto Rico serves 4,500 individuals.

The mission priority of these MTFs is to provide health care to active duty service members. In most cases, the next priority is family members, leaving the treatment of uniformed services retirees (particularly those over age 65) to a "space available" basis. This does not mean however that the MTFs exclude treatment to all uniformed services retirees. There is some space available at each MTF for treatment of uniformed services retirees. There is not, however, sufficient space available to treat all uniformed services retirees. The MTFs reserve a certain amount of space (i.e., quotas) for the treatment of uniformed services retirees to provide the MTF physicians and health care staff with opportunities to provide health care across a more diverse spectrum of the adult population. This patient population experiences a wider array of health care needs and conditions than experienced by the active duty and their family members who are presumably younger (and healthier). The "space available" policy allows MTF physicians and health care staff the opportunities to obtain experience with the needs of the older population. This is an important training opportunity that could not occur if treatment of uniformed services retirees were excluded altogether.

Preliminary findings from the Camp Pendleton Naval Hospital, and Ireland Army Community Hospital at Fort Knox, suggest that the first year of the Demonstration program had no effect on military readiness and training. The "space available" policy for treating uniformed services retirees provides a sufficient number of cases to ensure physicians and staff were well trained. Interviewed officials at both locations agreed that if uniformed services retirees no longer sought the "space available" care offered at their facilities, it would impact their ability to train physicians and, in turn, would impact readiness. They thought, however, that such an occurrence would be very unlikely.

H. Effects of a Permanent FEHBP Option on DoD, MTF, and OPM Budgetary Costs

Converting the FEHBP Demonstration into a permanent nation-wide option for eligible uniformed services retirees and their dependents would increase the number of eligible individuals from the approximately 129,000 located in the current demonstration sites to about 1.3 million individuals.[5] In the absence of other, more attractive options, this would potentially result in substantive costs to the DoD. However, the recently enacted "TRICARE-for-life" retiree health plan option, which entails little or no out-of-pocket liability to enrollees, will most likely considerably limit the number of individuals that would enroll in an FEHBP option as constituted in the Demonstration. In fact, given the expected popularity of the new program, DoD anticipates that other existing demonstration programs for uniformed services retirees will be terminated.

[5] This 129,000 includes eligibles from the two additional sites added during the second year of the demonstration.

The estimates presented in this section are predicated on the assumption that the "TRICARE-for-Life" program was not enacted. As such, the estimates reported here should be interpreted as upper bound estimates of the potential costs to the DoD and OPM of a fully implemented FEHBP Option for uniformed services retirees.

Finally, it should be noted that all of the expenditure estimates reported here are for the first year of a fully implemented national program.

Effects on DoD Budget

Three factors underlay the estimated effects on DoD's budget of making the Demonstration permanent. First, there are the current costs to the DoD due to Medicare-eligible uniformed services retirees' use of the MHS. Second is the expected enrollment rate, if the Demonstration was fully implemented. Finally, there are the direct costs to DoD for FEHBP premium payments.

Based on information provided by the OPM, we produced reasonably certain estimates on the FEHBP premium costs to the DoD. However, due to uncertainty on the number of eligible retirees that would enroll in an FEHBP product and the current MTF costs for these individuals, we produced a range of estimates on the total costs to the DoD. This range is reflected in the "low", "moderate" and "high" estimates reported in Table 14, below. The methodology used to produce these range values is described in Appendix A of the report.

Depending upon the assumed enrollment rate and MTF enrollee utilization rate, a permanent FEHBP program could result in increasing DoD costs of upwards of $108 million or generating savings of as much as $20 million, after accounting for reductions in MTF costs. Under most assumptions (i.e. 7.6 percent enrollment rate, medium prior MTF use), DoD costs would increase by about $34 million. Savings would come about from larger reductions in direct care costs, compared to FEHBP premium costs to DoD.

Table 14. Estimated Costs to DoD of a Permanent FEHBP Option.

Estimated Realized Costs of FEHBP Implementation*	Low Take Up Rate (5%)	Moderate Take Up Rate (7.6%)	High Take Up Rate (10%)
Estimated enrolled population	65,000	98,226	130,000
Estimated Change in DoD Costs (in millions of dollars)			
Assuming Low Prior MTF Utilization of FEHBP Enrollees	$ 54.0	$ 81.6	$108.0
Assuming Medium Prior MTF Utilization of FEHBP Enrollees	$ 22.3	$ 33.8	$ 44.7
Assuming Prior MTF Utilization of FEHBP Enrollees Equal to National Average	$ (9.9)	$ (15.0)	$ (19.9)

*Calculated as FEHBP Premium Costs less MTF cost reductions.
Source: Refer to Appendix A for a list of data sources.

Effects on MTF Budgets

The geographic distribution of the eligible retiree population is not necessarily similar to that of the MTFs. Further, based on the first-year results, enrollment rates would also vary across geography, and hence, across MTFs. Based on first-year enrollment results, it is likely that enrollment in a permanent, national FEHBP Option would be lower in sites with MTFs than in sites without MTFs. For these reasons, it is not possible to accurately estimate facility-specific, or even more aggregate sub-national budgetary impacts.

Because the Demonstration would result in fewer Medicare-eligible retirees obtaining care at MTFs, the direct effect of making the Demonstration permanent would be a reduction in MTF budgetary requirements. Specifically, we estimate that budgetary requirements would be reduced by between $65 million and $259 million (Table 15)

Table 15. Estimated MTF Savings from a Permanent FEHBP Option.

Estimated MTF Savings with FEHBP Implementation	Low Take Up Rate (5%)	Moderate Take Up Rate (7.6%)	High Take Up Rate (10%)
Estimated enrolled population	65,000	98,226	130,000
Estimated MTF savings (in millions of dollars)			
Assuming Low Prior MTF Utilization of FEHBP Enrollees	$65.4	$98.8	$130.8
Assuming Moderate Prior MTF Utilization of FEHBP Enrollees	$97.1	$146.7	$194.1
Assuming Prior MTF Utilization of FEHBP Enrollees Equal to National Average	$129.4	$195.6	$258.8

Source: Refer to Appendix A for list of data sources.

Effects on OPM Budget

For the first year of the Demonstration, OPM spent a total of $222,415 on the administration of the Demonstration project. This amount is comprised of employee salary, benefits, travel, and enrollment guide printing and distribution expenses.

In addition, OPM reports that, when asked, health plans indicated that the administrative work that it took to set up and managed the demonstration was enormous when weighted against the low enrollment rate. HMOs in particular find that administering a program for Medicare enrollees outside of a risk contract very difficult and costly.

I. EFFECTS ON PRESCRIPTION DRUG COSTS AND ACCESSIBILITY

We developed a range of estimates on DoD cost changes based on reductions in direct spending for prescription drugs and the share of FEHBP premiums that was attributed to prescription drug costs, based on information provided by OPM. This range was necessitated due to uncertainty in enrollment rates (see Section H) and current DoD prescription drug costs for eligible retirees who would most likely enroll in an FEHBP option. As presented in Table 16, below, we estimate that DoD direct spending on prescription drugs will decrease by between about $9 million and $34 million annually. However, due to the very large prescription drug cost share of FEHBP premiums (over 50 percent) relative to the share for MTF direct spending, total DoD prescription drug costs are estimated to increase from between $49 million and $115 million annually. The approach used to obtain these estimates is presented in Appendix A.

We were unable to obtain sufficient information to conduct a formal analysis of the impacts of converting the Demonstration to a permanent option on prescription drug access. Even so, qualitatively, we anticipate that such an expansion will increase retirees' access. With the exception of those in TRICARE Senior Prime or those eligible for BRAC pharmacy benefits, Medicare-eligible uniformed services retirees can obtain prescription drugs through DoD at MTFs on a space available basis. Those that currently have MTF access problems, due to geographic distance or other transportation-related limitations, would have the option under FEHBP to obtain prescriptions at local pharmacies. Further, those without access to Medigap or other supplemental insurance plan coverage, would face financial access problems. As such, it is reasonable to conclude that obtaining FEHBP drug coverage, which is also more generous than that of Medigap supplemental plans, would improve prescription drug access for this population.

Finally, the only quantitative information available suggests a substantive increase in prescription drug costs. This most likely reflects both an increase in access for individuals without prescription drug coverage and a substitution from other sources of coverage.

Table 16. Estimated MTF Prescription Drug Savings and Overall DoD Prescription Drug Costs Under a Permanent FEHBP Option.

Estimated Prescription Drug Expenditure Changes with FEHBP Implementation	Low Take Up Rate (5%)	Moderate Take Up Rate (7.6%)	High Take Up Rate (10%)
Estimated enrolled population	65,000	98,226	130,000
Estimated MTF Drug Savings (in millions of dollars)			
Assuming Low Prior MTF Utilization of FEHBP Enrollees	$8.5	$12.8	$17.0
Assuming Moderate Prior MTF Utilization of FEHBP Enrollees	$12.6	$19.0	$25.2
Assuming Prior MTF Utilization of FEHBP Enrollees Equal to National Average	$16.8	$25.4	$33.6
Estimated Total Prescription Drug Costs to DoD (in millions of dollars)*			
Assuming Low Prior MTF Utilization of FEHBP Enrollees	$57.4	$86.8	$114.8
Assuming Moderate Prior MTF Utilization of FEHBP Enrollees	$53.3	$80.6	$106.6
Assuming Prior MTF Utilization of FEHBP Enrollees Equal to National Average	$49.1	$74.2	$98.2

*Calculated as the estimated share of FEHBP premiums for prescription drug costs less MTF drug savings.

J. Other Information Relevant to the FEHBP Option and Its Future Role in Ensuring Health Care Coverage for Uniformed Services Retirees

Characteristics of FEHBP Enrollees and Factors Affecting the Enrollment Decision.

Characteristics of Enrollees Compared to Non-Enrollees

Substantial distinctions do not exist between the enrollees and non-enrollees for a number of characteristics. It can be concluded from the survey data that individuals were not disproportionately drawn to enroll/not to enroll in the Demonstration by demographic or economic attributes (Table 17). This indicates that conditions of the FEHBP Plan were not disproportionately attractive to certain demographics or economic groups, overall. The relatively larger share of enrollees of Hispanic/Latino ethnicity compared to non-enrollees reflects the relatively higher enrollment rates in Puerto Rico.

Table 17. Characteristics of the Eligible Population, by Enrollment Status (percent).

Respondent Characteristic	Enrolled in FEHBP	Not Enrolled in FEHBP	Total Eligibles
Gender			
Male	46.6	48.7	48.6
Female	53.4	51.3	51.4
Age			
Under 65	11.4	12.3	12.3
Over 65	88.6	87.7	87.8
Hispanic/Latino Ethnicity			
Yes	37.1	12.0	13.0
Belongs to Organization Representing Mil Retirees			
Yes	49.2	42.6	42.8
Race			
White	95.1	87.8	88.1
African American	3.4	6.2	6.1
American Indian/Alskn Native	0.2	0.3	0.3
Asian	1.0	4.6	4.5
Native Hawaiian/Pac.Islander	0.3	1.2	1.2
Education			
Less than 9th Grade	5.4	3.8	3.8
Some High School	5.9	7.1	7.0
High School Grad	29.3	34.0	33.8
Some College	29.3	30.4	30.4
College Graduate	12.3	9.9	10.0
Post Grad. Education	17.8	15.0	15.1
Yearly Income			
Less than $20,000	22.4	24.8	24.7
$20,000 to $30,000	34.8	39.2	39.1
$40,000 to $59,000	19.4	17.7	17.7
$60,000 to $79,000	11.4	8.5	8.6
$80,000+	12.1	9.8	9.9

Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

In general, there are few differences in the health status and functioning between the groups examined. For respondents, the most substantive differences in health-status related information were the reported presence of serious illness requiring medical care and the incidence of limited independence (Table 18). Fewer enrollees reported that these characterized their health status.

Table 18. Eligible Respondent Health Status, by Enrollment Status (percent).*

Respondent Characteristic	Enrolled in FEHBP	Not Enrolled in FEHBP	Total Eligibles
Present Health Status			
Excellent	9.1	8.4	8.4
Very Good	24.7	23.0	23.1
Good	33.4	34.8	34.7
Fair	26.6	25.2	25.2
Poor	6.2	8.7	8.6
Health Compared to Previous Year			
Much Better Now	5.6	5.7	5.7
Somewhat Better Now	10.5	8.6	8.7
About the Same	67.0	64.6	64.7
Somewhat Worse Now	14.6	17.3	17.2
Much Worse Now	2.3	3.9	3.8
Serious Illness Requiring Medical Care			
Yes	27.6	32.6	32.4
Limited Independence			
Yes	5.4	7.5	7.5

Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

For spouses and dependents of respondents, a similar pattern exists with regard to health status measures (Table 19). Non-enrolled spouses more frequently reported having limited independence.

Table 19. Eligible Spouse Health Status, by Respondent's Enrollment Status (percent).

Characteristics of Spouse	Enrolled in FEHBP	Not Enrolled in FEHBP	Total Eligibles
Present Health Status			
Excellent	8.4	8.1	8.1
Very Good	26.2	26.0	26.0
Good	36.1	34.0	34.2
Fair	23.0	24.5	24.4
Poor	6.3	7.4	7.4
Health Compared to Previous Year			
Much Better Now	4.0	3.2	3.2
Somewhat Better Now	9.8	8.8	8.9
About the Same	72.7	69.7	69.9
Somewhat Worse Now	11.6	14.8	14.7
Much Worse Now	1.9	3.4	3.3
Serious Illness Requiring Medical Care			
Yes	26.1	29.5	29.3
Limited Independence			
Yes	5.0	7.0	6.9
Serious Illness Req. Medical Care (Dep.)			
Yes	15.3	16.3	16.3

Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

Factors Affecting the Enrollment Decision

The key factors affecting the enrollment decision are relative plan costs, benefit coverage, and satisfaction with current coverage. The importance of cost is evident both in terms of stated reasons for enrolling/not enrolling (Tables 20 and 21), and also by comparing what the eligible population members were paying in 1999 premiums and the FEHBP premiums paid by enrollees in 2000 (Table 22). In all demonstration sites, enrollees reported paying on average higher premiums relative to non-enrollees in 1999. More importantly, in virtually all instances, the average FEHBP premiums paid in 2000 were lower than those paid by enrollees for other coverage in 1999.

Table 20. Reasons for FEHBP Enrollment.

Reasons for Enrollment*	Percent of Enrollees Identifying Statement as an Enrollment Reason	Percent of Enrollees Identifying Statement Main Reason for Enrollment
Needed Better Prescription Coverage	64.4	23.5
Benefits Package Meets Needs of Self/Family	66.7	18.9
Benefits are Better than Other Coverage I Could Get	50.8	13.1
Costs Less than Other Coverage Available to Me	62.1	11.6
Costs Less than Previous Coverage Arrangement	49.8	8.6
Other Enrollment Reason	10.0	4.4
Spouse Joined-More Convenient if I Join as Well	34.6	4.3
Broader Choice of Doctors than Previous Coverage	26.5	3.4
Can Select Current Dr. Under Plan	62.5	3.2
Can't Count on Getting Space Available Care	27.1	3.1
Many Civilian Dr.'s Don't Accept CHAMPUS/TRICARE	20.5	2.7
Plan has Good Reputation for Quality of Care	44.7	2.0
Don't Want to Use Military Care	22.2	0.9
Friends/Relatives Recommended FEHBP	14.2	0.4

*sorted by Main Reason for Enrollment
Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

Table 21. Reasons for Not Enrolling in the FEHBP Demonstration.

Reasons for Non-Enrollment	Percent Non-Enrollees, Who Did Not Consider FEHBP, Identifying Statement as a Non-Enrollment Reason	Percent Non-Enrollees, Who Considered FEHBP, Identifying Statement as a Non-Enrollment Reason
Satisfied With Current Coverage Arrangement	68.7	49.5
Too Costly	26.7	37.9
Would Not be Able to Use Military Pharmacies	25.0	29.6
Program is New, Waiting to See How it Works Out	24.8	32.1
Unclear on How it Would Work With Medicare	23.6	34.5
Could Not Keep Current Dr.'s in FEHBP	23.4	32.0
Demonstration Will End in Three Years	18.1	34.5
Feared Inability to Get Medicare Supp. Back at Demo. End	15.7	34.6
Other Non-Enrollment Reason	15.4	17.2
Would Not be Able to Get Care at MTFs	15.2	11.7
Did Not Have Enough Information to Make a Decision	11.9	20.5
Would Not be Able to Get Care at VA	10.2	10.0
Feared Inability to Get Retiree Cov. Back at Demo. End	9.9	15.0
Could Not Decide Which Plan to Join	7.0	17.7
Spouse Did Not Want to Join-Therefore I Did Not	6.3	3.8
In-Eligible	4.9	3.2
Friends/Relatives Recommended Against It	4.2	7.4
Did Not Know About FEHBP Demonstration	3.7	2.7
None of the Plans Available Had a Good Reputation	3.1	2.6

Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care".

Table 22. Average non-Medicare Premiums Paid in 1999 by Enrollees and Non-Enrollees and FEHBP premiums paid by Enrollees.

Enrollment and Actual Average Cost of FEHBP	Number of Enrollees*	Weighted Average Cost Per Month of Non-Medicare Coverage for Non-Enrollees* (1999)**	Weighted Average Cost Per Month of Non-Medicare Coverage for Enrollees (1999)**	Actual Weighted Average Premium Paid for Selected FEHBP Plans
By Site				
Dover, De				
Self	11	$102.06	$143.79	$97.68
Family	24	$125.63	$194.47	$157.72
Puerto Rico				
Self	196	$50.00	$75.93	$59.30
Family	719	$78.60	$125.60	$95.44
Fort Knox, KY				
Self	46	$36.51	$66.41	$70.98
Family	88	$200.85	$149.27	$129.16
Greensboro/Winston Salem, NC				
Self	53	$65.37	$79.78	$73.21
Family	232	$168.70	$182.81	$121.35
Dallas, Texas				
Self	106	$79.77	$101.13	$73.19
Family	414	$137.94	$160.82	$136.91
Humboldt County, CA				
Self	42	$66.67	$112.61	$73.59
Family	179	$85.42	$172.93	$133.25
Camp Pendleton, CA				
Self	68	$55.81	$106.42	$92.28
Family	235	$83.64	$164.16	$150.53
New Orleans, LA				
Self	34	$75.97	$92.01	$79.76
Family	62	$116.67	$154.21	$123.73

*Those who considered but did not enroll

**Mean Values are obtained by choosing midway points between the various $ ranges presented in the questionnaire, and applying that value to each individual who selected that range. The weighted mean $ value is then generated. The highest possible values on the survey do not have any upper limit (e.g. "$500 or More"), however, and it is therefore impossible to assign a value to them. Each of the estimated means is necessarily lower than the true mean, therefore, as the highest values are not included in the mean. As such, these values should not be used to impute actual health care costs, but rather for relative comparisons of costs across groups.

Source: Analysis of the "Health Care Survey of Medicare Eligible Military Retirees and Others Eligible for Military Health Care" and administrative data on FEHBP premiums.

The Effect of New Uniformed Services Retiree Health Program on the Future Viability of the FEHBP Option

In the Fall of 1999, DoD and OPM implemented the FEHBP Demonstration to test the feasibility, desirability, and effects of offering uniformed services retirees the option to enroll in the FEHBP. Uniformed services retirees have not, in the past, been guaranteed retiree health benefits by the DoD. For uniformed services retirees who reside in areas served by MTFs, medical care was available through MTFs on a space available basis. However, because retirees were given low priority for service in MTFs, this care was not guaranteed. As a result, many uniformed services retirees and their dependents either were uninsured or were required to make other individual arrangements for their health care. The FEHBP option was developed, as one of several demonstration programs, to address the problems in health care and health insurance access faced by retirees and their dependents. It allows uniformed services retirees to choose a health plan offered by FEHBP, on a voluntary basis, with DoD paying a majority of the premium cost and the enrollee paying the residual premium amount. For those retirees without other health insurance coverage, or who are not able to access services due to the inaccessibility of an MTF, the FEHBP option offers the opportunity to obtain accessible insurance coverage and services.

In the Fall of 2000, Congress enacted new legislation that dramatically changed the landscape for uniformed services retirees. This legislation directs DoD to provide comprehensive health care coverage and/or services to all uniformed services retirees and their dependents, beginning October 1, 2001. While the details of this new program are not yet determined, it is clear that it will offer comprehensive health care benefits for life, at no premium cost to uniformed services retirees.

"TRICARE-for-life" will likely supercede all other options that are, or have been, considered for providing insurance or health care benefits for uniformed services retirees. It is expected to offer comparable benefits to those available to retirees through the FEHBP option. In addition, it will be provided at no cost to retirees, while the FEHBP option requires enrollees to pay approximately 25 percent of the premium cost of the elected health plan.

During 2001, until the implementation of "TRICARE-for-life" in October, the FEHBP option will continue to be an attractive one for uniformed services retirees who do not have other health insurance options, who are paying more for their alternative health insurance than the cost of a comparable FEHBP plan, and/or who cannot access services in an MTF. Once "TRICARE-for life" is implemented, however, it is likely that few, if any, retirees would consider the FEHBP option as an attractive one.

K. ENROLLMENT FREQUENCY RECOMMENDATIONS

Public Law 105-261 requires that this report make certain recommendations on how many opportunities eligible beneficiaries should have to enroll in the FEHB Program should this become a permanent offering. The three options detailed by the legislation are whether eligible beneficiaries—

"1. should be given more than one chance to enroll in the demonstration project under this section;

2. should be eligible to enroll in the project only during the first year following the date that the eligible beneficiary becomes eligible to receive hospital insurance under part A of title XVIII of the Social Security Act; or
3. should be eligible to enroll in the project only during the 2-year period following the date on which the beneficiary first becomes eligible to enroll in the project."

We are in the process of evaluating these options and will make our recommendation in the *Second Report to Congress*.

APPENDICES

APPENDIX A: METHODS AND DATA

Methods

General Approach

A two stage methodological approach was used for developing the majority of the findings contained in this report. The first stage involved assembling an analytic database that contained sufficient information necessary to address the questions of interest to this report. The second stage consisted of generating series of tabulations, comparing various subgroups of the eligible population for variables of interest.

Cost Estimate Approach

As noted in Section H of the report, the key factors driving the cost estimates are the proportion of eligible uniformed services retirees that would enroll in an FEHBP option, the current health care costs of these individuals to DoD, and the FEHBP premium costs to DoD of these individuals.

FEHBP Enrollment Rate

The observed first year Demonstration enrollment rates were lower than anticipated. Converting a Demonstration into a permanent program, however, would tend to increase interest and perhaps enrollment in the option. Further, based on the survey data, over half of the eligible population was unaware of the Demonstration's existence. Overtime, as this segment of the population acquires information, an unknown number of individuals would mostly likely opt to enroll, which would also increase the overall enrollment rate. In contrast, interest in the FEHBP option could be lower in other non-demonstration site areas due to greater access to MTFs, the availability of other demonstrations (e.g., Medicare Subvention), and more alternative health insurance options.

For calculating the estimates reported here, we assumed that the enrollment rate of those eligible retirees within knowledge of the Demonstration (7.6 percent) was most reflective of the rate that might result from a fully implemented national-based system. However, due to uncertainty, we also used a "low" enrollment rate (5.0 percent) and a "high" enrollment rate (10.0 percent) to calculate the cost estimates.

Current Health Care Costs of FEHBP Enrollees

Direct estimates of current MTF costs for over-65 uniformed services retirees and their dependents that enrolled in the Demonstration were not available for this report. Instead, we relied on available statistics to obtain estimates of these costs.

As a starting point, we used estimated per capita direct care costs of $2,340 for all over-65 uniformed services retirees.[6] Next, we adjusted this estimate downward adjustment to reflect lower health service utilization by under 65 Demonstration enrollee dependents.[7] This adjusted estimate, however, reflects average costs for all retirees (with a similar number of dependents) across the United States, most of which are most likely located in closer proximity to MTFs than those individuals in the demonstration sites. As such, we deemed these to be upper bound estimates of the utilization costs of individuals that would enroll in an FEHBP plan, if such a plan were available.

This upper bound cost estimate was then adjusted to reflect the utilization rates of those most likely to enroll in an FEHBP plan. The results of the survey data indicate that enrollees in the Demonstration sites relied less frequently on MTFs for care than did non-enrollees.[8] In addition, because the demonstration sites contained very few MTFs, all individuals in these sites used MTFs less frequently than would the average uniformed services retiree with greater access to these facilities. Past research has indicated that over-65 retirees in non-catchment areas used MTFs only about 50 percent as frequently as retirees within catchment areas.[9] Making these two adjustments yielded a lower bound estimate of the average per capita costs for MTF use by those most likely to enroll in an FEHBP plan. Finally, due to uncertainty in the actual costs by these individuals, we estimated a "medium" cost estimate.

FEHBP Premium Costs

The third factor is the direct costs to DoD for FEHBP premium payments. Unlike the other factors, these direct costs are known with more certainty. Based on data provided by the OPM, we were able to determine the actual DoD premium costs for those enrolling in the Demonstration. Assuming that (potential) enrollees, in non-demonstration areas selected a similar mix of plans and faced a similar set of prices as did actual first-year enrollees in the demonstration sites, we estimated the total DoD premium costs by multiplying an enrollee-weighted average premium by the estimated number of enrollees at the national level.

Prescription Drug Costs

As with total health care expenditure costs, data were not available to directly estimate MTF prescription drug savings or overall DoD prescription drug costs under full implementation of the FEHBP Demonstration. We therefore applied the same methodology as we had for overall costs, generating separate estimates of MTF savings and FEHBP costs attributable to prescription drugs, and subtracting to get a final estimate of overall prescription drug costs to DoD.

[6] This estimate was reported in Cost Estimate of H.R. 3573: Keep Our Promise to America's Military Retirees Act, Congressional Budget Office, March 28, 2000..

[7] Approximately 9 percent of enrollees were under-65 spouses and dependents.

[8] We estimated that enrollees used MTFs about 13 percent less than non-enrollees did.

[9] Hosek, Bennett, et al. The Demand for Military Health Care: Supporting Research for a Comprehensive Study of the Military Health-Care System. *Rand*, 1995.

Current Prescription Drug Costs of DoD Enrollees

Our approach relied upon obtaining an estimate for prescription drug expenditures as a percentage of overall MTF costs. Because uniformed services retirees are eligible to receive free prescription drugs through MTFs, and may use MTFs like a wrap-around prescription drug benefit to some degree, it was not appropriate to use an estimate based on the Medicare population as a whole. Rather, we used estimates from the VA system to more closely approximate prescription drug shares for uniformed services retirees at MTFs. Analysis of medical expenditure patterns for the VA population yielded a drug share estimate of nearly 13 percent of total VA costs.[10] Using that value, we generated estimates of prescription drug cost savings to MTFs, dependent upon take-up rates and relative MTF utilization levels.

FEHBP Prescription Drug Costs

We relied on actual DoD FEHBP claims data, furnished by OPM, to produce estimates of prescription drug expenditures under full implementation of the Demonstration. As might be expected, we found that FEHBP enrollees seem to be using their plan much like a supplemental drug benefit. Prescription drug expenditures therefore account for nearly 55 percent of per capita medical costs. To obtain estimates of overall Demonstration costs attributable to prescription drugs, we applied that share estimate to the average per capita DoD FEHBP premium.

Data

The primary source of data for this Report was the Survey of the Eligible Population, which is discussed in detail in the following Section. This survey was augmented with additional information from a number of sources. Administrative information on the eligible population provided by the Iowa Foundation. The GAO provided information on Medicare Part B participation, FEHBP premiums, and geographic location codes. Information on Medicare risk plan and Medigap Supplemental plan availability was obtained from Health Care Financing Administration public use files. Qualitative information on the Demonstration marketing campaign and the demonstration sites was obtained through a series of structured telephone interviews conducted by Westat, Inc. Finally, a variety of published statistics were used for producing the various cost estimates.

[10] Barents Group analysis of 1996 Medicare Current Beneficiary Survey, Cost and Use File., Health Care Financing Administration

APPENDIX B: DESCRIPTION OF THE HEALTH CARE SURVEY OF MEDICARE ELIGIBLE UNIFORMED SERVICES RETIREES AND OTHERS ELIGIBLE FOR MILITARY HEALTH CARE

This appendix provides a detailed description of the methods used to field the "Health Care Survey of Medicare-Eligible Military Retirees and Others Eligible for Military Care". The Demonstration and evaluation are being conducted in eight sites: Dover Air Force Base, DE; Commonwealth of Puerto Rico; Fort Knox, KY; Greensboro/ Winston-Salem/High Point, NC; Dallas, TX; Humboldt County, CA; Naval Hospital Camp Pendleton, CA and New Orleans, LA. All eight sites received the same questionnaire. A Spanish version of the questionnaire was sent to beneficiaries in Puerto Rico.

Questionnaire development

The GAO developed the questionnaire. Westat and GAO collaborated on finalizing both the English and Spanish questionnaires. Westat participated in the testing and provided input for fine tuning both the English and Spanish questionnaire.

The year 1 questionnaire included items on the following topics:

- Use of Health Care in 1999
- Health Status
- About the respondent's family-their use of health care, health status
- About the Demonstration
- Other Insurance Coverage
- Demographics

All survey material, including questionnaires, reminder/thank you postcards and envelopes were produced by GAO. Westat produced the cover letters on GAO letterhead.

Sampling strategy

The sample was drawn from uniformed services retirees in the eight demonstration sites who had enrolled in the FEHBP Demonstration and eligible uniformed services retiree who had not enrolled in the Demonstration. As shown in Table A-1 the enrollee population size in all eight sites combined is 2,507 and the non-enrollee population size in 66,535.

The enrollee sample included all enrollees who were the sole enrollee in their household. However in households with multiple enrollees only one enrollee was selected for the sample. This resulted in an enrollee sample size of 1676.

For the non-enrollee sample three sampling strategies were examined:

- a proportional allocation sample would result in the best precision for point estimates for the entire population,
- an equal allocation sample would have the greatest power to detect differences among the eight demonstration sites, and
- a matched sample would have the greatest power to detect differences between enrollees and non-enrollees.

It was difficult to select one strategy as optimal, because the evaluation has multiple objectives. Two blended strategies were proposed: the first blended proportional allocation with equal allocation, and the second blended proportional allocation with a matched sample. GAO conducted a simulation of each approach: in the first, an equal allocation sample was progressively modified to bring it closer to proportional allocation, and in the second, a matched sample was progressively modified to bring it closer to proportional allocation. In both cases, the gain in precision and power from increasing the sample of non-enrollees by a 10 percent using a modified strategy was assessed. The gain in precision was calculated by taking the relative percentage of two coefficients of variation (CV) around any point estimate – that is, CV1, based upon the modified sampling allocation, and CV2, based upon the proportional allocation. The simulation was subject to the following rules and constraints:

- Starting with an expected realized enrollee sample size of 1257, increase each site's sample size (based on equal sampling/matched sampling) by 10% if and only if the sample size according to equal/matched sampling was less than under proportional allocation;
- Repeat the 10% increase until the sample size for adjusted equal/matched allocation attained maximum allowable AND the sample size of non-enrollees at each site is at least 100; and
- At each incremental stage, the power of detecting a difference between enrollees' and non-enrollees' at each site was observed and the relative CV (=CV1/CV2, adjusted equal (or adjusted matched) versus proportional allocation) was calculated.

Among the plans proposed, adjusted equal allocation provides better power for the sites with low enrollment rate (less than 2 percent – Dover, Ft. Knox, New Orleans, and Camp Pendleton) than unadjusted equal allocation or adjusted matched allocation. It also provides comparable power for the other sites, yet gives the lowest coefficient of variation (CV) compared to unadjusted equal allocation or adjusted matched allocation.

Table A-1 shows the distribution of the final expected sample across the eight sites. The sample includes 1257 enrollees and 2858 nonenrollees. These numbers assume a 72 percent response rate from non enrollees (2858 respondents from a sample of 3971) and a 75 percent response rate from enrollees (1257 respondents from 1676 enrollees).

Table A-1. FEHBP Demonstration Sampling Plan for Nonerollees – Proportional Allocation and Alternatives*

Site Enrolled Under	Enrollees' Population Size	Non-enrollees' Population Size	Enrollees' Sample Size	(Non-enrollee) Proportional Allocation (A)	(Non-enrollee) Equal Allocation (B)	(Non-enrollee) Adj. Equal Allocation (C)	(Non-enrollee) Adj. Matched Allocation (D)	Sampling Fraction (A)	Sampling Fraction (B)	Sampling Fraction (C)	Sampling Fraction (D)	Power Pro-portional Allocation (A)	Power Equal Allocation (B)	Power Adj. Equal Allocation (C)	Power Adj. Matched Allocation (D)
Dover	35	4,349	20	187	356	275	73	0.04	0.08	0.06	0.02	0.23	0.24	0.24	0.20
Puerto Rico	913	5,994	448	257	356	379	424	0.04	0.06	0.06	0.07	0.91	0.96	0.97	0.98
Ft. Knox	134	7,623	74	327	356	482	274	0.04	0.05	0.06	0.04	0.60	0.60	0.64	0.58
Greensboro	285	2,993	140	129	356	189	212	0.04	0.12	0.06	0.07	0.58	0.78	0.68	0.70
Dallas	520	13,087	263	562	356	524	926	0.04	0.03	0.04	0.07	0.96	0.91	0.95	0.98
Humbolt	221	2,698	113	116	356	170	191	0.04	0.13	0.06	0.07	0.53	0.73	0.61	0.64
Camp Pendleton	303	24,804	148	1,057	356	524	562	0.04	0.01	0.02	0.02	0.89	0.79	0.84	0.84
New Orleans	96	4,987	53	214	356	315	199	0.04	0.07	0.06	0.04	0.46	0.50	0.50	0.46
Total	2,507	66,535	1,257	2,849	2,848	2,858	2,851	0.04	0.04	0.04	0.04	0.98	0.98	0.98	0.98
											CV%	1.77	2.31	1.99	2.04

Note: Actual number of questionnaires that are sent out will be 25% higher for enrollees and 35% higher for nonenrollees sample.
This reflects all types of non-response (which is assumed to be higher among nonenrollees).
Total expected responses (n1) are 4,108 (2,851 + 1,257) and total mailouts are 6,062 (1,676 + 4,386) –68% of overall expected response rate.

Note: Sampling Plan "C" was selected

Data collection protocol

A mail-only protocol was used to administer the questionnaire. The protocol specified four mailings:

- First survey mailing with a cover letter on May 24, 2000
- Reminder/thank you postcard on June 6, 2000
- Second survey mailing with a cover letter on June 21, 2000
- Third survey mailing with a cover letter on July 10, 2000

In-bound toll-free line. Two toll-free phone lines, one for English speakers and the other for Spanish speakers, were established. Respondents were encouraged to call the toll free number if they had questions or concerns about the survey or needed another copy of the questionnaire. Trained telephone interviewers at Westat's Telephone Research Center answered calls.

Six interviewers including one Spanish interviewer and one bilingual interviewer were trained for half a day on project-specific details and on general procedures for handling incoming calls. The project training included a review of the questionnaire and a detailed discussion of frequently asked questions anticipated by Westat staff. Each interviewer was also provided pre-printed answers for these questions. Interviewers logged all calls and voice mails, and then forwarded the information to the project staff for follow-up. These call logs were then reviewed by project staff. Information from the logs were then entered into an Access database that houses the respondent sample database described below. In most cases follow-up involved mailing another survey to the respondent.

Tracking survey mailings. The sample file provided by GAO was loaded onto an Access database. All respondents were assigned an ID number to facilitate tracking through the data collection period. This database included information on when each wave was mailed, date when each questionnaire was returned, the result code, address updates if any, and the remailing status. The result codes indicate if the questionnaire was a complete, in English or Spanish, refused, or not delivered. In addition, the result codes indicate whether the respondent is deceased, ineligible, or any other non-response.

Westat initiated a parallel remailing process in addition to the regular mailing. Questionnaires were remailed for the following reasons: the post office returned the questionnaire with a new address, a respondent from Puerto Rico requested an English questionnaire, respondents requested another questionnaire for any other reason, or if Westat received a new address from GAO. In a few cases the post office returned the questionnaire as a non-deliverable with no forwarding address. Westat the forwarded these names and old addresses to GAO for an address update. Once Westat received a new address, a new survey package was mailed to the respondents. The remailing process was also tracked in the same access database described above.

In some questionnaire booklets from the first mailing, pages 3, 4, 9 and 10 were repeated and pages 5-8 were missing. The error was detected when a few respondents called in for another

copy of the questionnaire as the one they received had duplicate pages. The missing pages included questions D3-D17, which were about the Demonstration program. Westat then reviewed every returned questionnaire to determine if it contained the printing error. The returned questionnaires containing the printing error were coded appropriately in the database and stored separately for follow-up action.

The follow-up action involved remailing a complete questionnaire to those who had received one with a printing error. This packet contained a new cover letter apologizing for the error and requesting their cooperation in completing missing questions. The remailed questionnaires included an insert, in green, with the missing questions.

Respondents that had returned a questionnaire with the printing error received a new survey packet depending on their answers to Question D1 on page 4. Question D1 on page 4 asked "Before receiving this questionnaire, did you know, as part of the new Demonstration, that you could join an FEHB-sponsored health plan?" The possible answers to this question are "Yes" and "No." Respondents who answered "No" were instructed to skip to Question E1 on page 9. Those who answered "No" to Question D1, therefore, were able to skip over the missing pages to page 9. Those who answered "Yes" to this question were not instructed skip to page 9 and instead answered questions on pages 5-8. Therefore, the questionnaires were remailed only to those who answered "Yes" to Question D1, since these were the only cases in which the printing error would result in a loss of information. As of July 18, 2000 we had received 192 misprinted surveys of which 109 were mailed back. (See Table A-2 in Response Rates section for a detailed breakdown of the sample.)

Response rates

We closed data collection with a final tally of 4787 completed questionnaires and a response rate of 85.3%.

Table A-2

Total Mailed	**5647**
Total Mail Received	**4886**
Complete	4787
English	3659
Spanish	949
completed misprinted survey D1=No	85
final completed misprinted survey	94
Deceased	27
Refusal	36
Ineligible	11
Other Non-Response	786

Adjusted response rate
{Completes/total mailed-(deceased+ineligible)} **85.3%**

Table A-3 lists data collection results by site and by enrollment status. It is interesting to see that the response rate from the enrollees (94%) is considerable higher than the response rates from the non-enrollees (81%). This difference could be on account of saliency of the topic to the enrollees.

Table A-3

SITE	Total Mailed	#of enrollees in sample	# of nonenrollees in sample	Total returns	Total completes	Raw response rate	# of enrolled completes	% of enrolled completes	% of non-enrolled completes
Dover AFB, DE	414	26	388	347	334	80.68%	24	92.31%	79.90%
Puerto Rico	1102	597	505	971	961	87.30%	561	93.97%	79.41%
Fort Knox, Kentucky	774	98	676	645	625	80.75%	90	91.84%	79.14%
Greensboro, North Carolina	455	187	268	419	411	90.33%	183	97.86%	85.07%
Dallas, Texas	1081	350	731	958	941	87.05%	323	92.29%	84.54%
Humboldt County, CA	382	150	232	344	336	87.96%	143	95.33%	83.19%
Camp Pendleton, CA	949	197	752	810	796	83.88%	187	94.92%	80.98%
New Orleans, LA	490	71	419	392	383	78.16%	65	91.55%	75.89%
Total	5647	1676	3971	4886	4787	84.79%	1576	94.03%	80.89%

Weighting

Sampling probabilities

The sample design used to collect data for the study is a stratified two-stage design, where uniformed services retiree households were selected by simple random sampling within a stratum and one eligible person was selected from each selected household by again simple random sampling. Sample selection was done within each site separately and within each site, enrollee and non-enrollee households were separated into two different strata. Then enrollee households were sampled 100 percent (i.e., with probability 1) but non-enrollee households were sampled with a probability far less than 1.

To simplify notation, the discussion will focus on a given site. Let P_{1j} be the probability of selecting enrollee household j and P_{1jk} be the probability of selecting enrollee retiree k within household j in the given site. Similarly, P_{2j} and P_{2jk} are defined for the nonenrollee stratum. Note that the subscript i indicates enrollee/nonenrollee stratification, i.e., i =1 means the enrollee stratum and i =2 means the nonenrollee stratum. Note also that P_{1j} =1. N will be used to denote the population size and n for the sample size. So, N_1 denotes the population number of the enrollee households (of the given site) and N_{1j} denotes the number of eligible persons in enrollee household j. Likewise, n_1 indicates the enrollee household sample size and n_{1j} the number of persons selected from selected enrollee household j, which is always one. N_2, N_{2j}, n_2, and n_{2j} for the nonenrollee stratum are similarly defined. Here again, n_{2j}=1 always. Since simple random sampling was used to select households and persons from the selected households, the sampling probabilities can be expressed in terms of N's and n's, namely,

$$P_{ij} = n_i / N_i = 1 \text{ and } P_{ijk} = n_{ij} / N_{ij} = 1/N_{ij} \quad (1)$$

Then the base household and person weights can be obtained using these probabilities.

The weighting procedure

The steps involved in weighting are as follows: (1) compute the base household weight; (2) adjust the base household weight for nonresponse; (3) compute the person base weight using the nonresponse adjusted household weight; (4) produce the person level final weight using post-stratification with population level gender data. In the following, each step is described in detail.

Step 1: Compute the base household weight

The base household weight for sample household ij is the inverse of the sampling probability of the household as given by

$$w_{ij} = 1/P_{ij} = N_i / n_i \cdot \quad (2)$$

This simplifies to w_{1j} for the enrollee stratum.

Step 2: Adjust the base household weight for nonresponse

Household and person nonrespondents are identical since only one person was selected from each selected household. If the selected person did not respond, the corresponding household is a nonrespondent. For this reason, we can attach a person characteristic to the household for the purpose of nonresponse adjustment. For example, the person's gender can be considered as a household characteristic for this purpose. As explained later, it was found that the response propensity was highly associated with the gender variable of the sample person and so was for the sample household. Therefore, nonresponse weight adjustment was carried out within weighting classes formed by the gender variable. It was desired to keep nonresponse adjustment within design strata by site. There were 32 weighting cells (8 sites x 2 strata x 2 gender groups) initially. When the cell size was less than 20, it was collapsed to the other gender cell within the same stratum and site. Both gender cells of the enrollee stratum in Site 1 (Dover, AFB, DE) were of cell size less than 20 and they were collapsed together into one cell, resulting in 31 weighting cells all together.

Within each weighting cell, let S_{ic} be the set of sample households and let be the set of respondent households. Then the nonresponse-adjusted household weights are given by

$$w_{ij}^{(\mathrm{H})} = w_{ij} \frac{\sum_{j \in S_{ic}} w_{ij}}{\sum_{j \in R_{ic}} w_{ij}} . \tag{3}$$

Step 3: Compute the person base weight

The person base weight was computed using the nonresponse adjusted household weight given in (3) and the person level selection probability given in (1) as follows:

$$w_{ijk} = w_{ij}^{(\mathrm{H})} / P_{ijk} = w_{ij}^{(\mathrm{H})} N_{ij} . \tag{4}$$

Step 4: Post-stratification for the person level final weight

This was the last step to further adjust the person weight given in (4) by post-stratification using the known population counts by gender. The post-strata were defined by the gender variable only for the nonenrollee strata since there were too many missing values on the gender variable (17%) in the enrollee strata. Missing values also occurred in the non-enrollee strata but much less frequently (0.2%). So it was decided to apply post-stratification to the non-enrollee strata only.

The population counts that were adjusted for missing genders were used so that the counts sum up to the known population size. For the enrollee strata, the person weights were simply ratio-adjusted to the known population size disregarding the gender. Within each site, the final person weight is then defined by

$$w_{ijk}^{(\mathrm{P})} = w_{ijk} \frac{M_g}{\sum_{k \in R_{ig}} w_{ijk}} , \tag{5}$$

where if person *ijk* is an enrollee stratum (i.e., i =1), then M_g is the stratum population person count and R_g is the set of respondents from the stratum disregarding the gender, but if the person is the non-enrollee stratum (i.e., i =2),, then M_g is the stratum male (or female) population count and R_g is the set of male (or female) respondents from the stratum.

Analysis weights

When the analysis unit is the household, the weight given in (3) should be used. If the analysis unit is the person, then the weight given in (5) should be used.

Construction of nonresponse adjustment cells

Nonresponse weighting adjustment is often carried out using weighting cells constructed to reduce nonresponse bias in survey estimates. Because analysis will be performed by enrollee status within each site, it was required to keep the nonresponse adjustment within these analysis domains (coincided with the design strata) and therefore, the weighting cells should be constructed within these domains.

Weighting cells are constructed using auxiliary variables available for the whole sample. The more abundant the auxiliary variables are, the better weighting classes can be constructed. In our cases, there are only two auxiliary variables, gender and age, available for the whole sample besides the design variables (site and enrollee status). It is often the case that demographic variables such as these are correlated with survey variables on the human subject. In this situation, some of bias in survey estimates due to nonresponse can be eliminated by using weighting cells constructed by those auxiliary variables when the response propensity is correlated with the auxiliary variables (and so with the survey variables).

To see whether these variables are correlated with response propensity, contingency table analysis was performed. The age variable was used to create two age categories: below 70, and 70 and over. Then a 2 by 2 contingency table was constructed by crossing the response status and gender or age category for each of enrollee and nonenrollee strata within each site. Chi-square test and Fisher's exact test were performed to statistically examine whether the two variables (response status and gender, or response status and age category) are associated or not. The sample units were assumed to be independently selected ignoring the fact that they were actually selected without replacement from a finite population. Therefore, the test results are conservative in the sense that the null hypothesis of no association is not rejected more often than should be. A significant test result means that the test shows an evidence of association. The test results with a significance level of 5% are given in tables 1 and 2 in Attachment 1. When the gender or age is missing, those cases were excluded from the analysis. The gender variable is missing more often than the age variable. Therefore, the sample sizes given in the two tables are not the same. The two tests (Chi-square and Fisher) agreed for all cases except one (the enrollee stratum in Site one).

In general, for the enrollee stratum, both auxiliary variables were not strongly associated with response status. For the nonenrollee stratum, however, the gender variable was strongly associated with response status, while the age category was not.

Based on these results, only the gender variable was used to construct nonresponse adjustment weighting cells. The weighting cells were constructed within each stratum for each site separately, resulting in 32 weighting cells. If, however, the cell sample size was less than 20, the cell was collapsed with the other gender cell within the same stratum and site. The stratum and site boundaries was never be crossed to collapse weighting cells.

There were 114 cases with missing gender variable (2% of the total sample size). Out of these, only 31 cases remained missing after transferring the survey observed gender value. For these remaining 31 cases, which were mostly from the non-enrollee strata, the missing gender values were imputed before constructing the weighting cells using hot-deck imputation with selection of donors from the same stratum.

One may argue that separate weighting adjustment for the two gender groups is not necessary for the cases with insignificant test results. About one half of the 16 cases (8 sites times 2 strata) had insignificant results and these cases were highly concentrated in the enrollee strata. However, separate weighting adjustment for the two gender groups was performed in all 16 cases regardless of the test results as long as the weighting cells satisfied the minimum cell size condition (20) – there was one case (the enrollee stratum in Site one, Dover AFB, DE) that violated the condition, having only 9 females and 17 males. A significant test result does not imply absolute lack of association between the response status and the gender variable for the case. Rather, it means that there is not enough evidence to reject the null hypothesis of no association. It is a matter of degree. Therefore, the strategy of across the board adjustment regardless the test results will not do much harm to the data since the response rates are similar for those cases anyway. There is an issue of variance, however, when weighting cells are too small in size. That is precisely why the minimum cell size condition was imposed.

There is another justification for the strategy. As mentioned earlier, the tests were conducted assuming that the sample units were selected independently. However, this is far from truth for the enrollee strata since enrollee households were selected with certainty and person level sampling rates were very high (over 50% for all sites). If this fact had been taken into account in the test statistics, the test results would have been significant for the most cases even for the enrollee strata.

Attachment 1

Table 1. Test results for 2 by 2 contingency tables (response status vs. gender)

Site	Enrollee/ Nonenrollee	Sample Size	Response Rate (%)		P-Value (%)		Significance at 5%	
			Male	Female	Chi-square	Fisher	Chi-square	Fisher
1	Enrollee	26	100.0	77.8	4.3	11.1	Yes	No
	Nonenrollee	373	89.6	76.1	0.1	0.0	Yes	Yes
2	Enrollee	596	94.4	93.7	71.8	72.8	No	No
	Nonenrollee	474	83.5	74.2	1.4	1.8	Yes	Yes
3	Enrollee	97	96.4	88.1	11.9	23.3	No	No
	Nonenrollee	662	85.4	74.5	0.1	0.0	Yes	Yes
4	Enrollee	186	98.6	97.6	65.3	53.8	No	No
	Nonenrollee	263	89.4	78.6	1.9	2.3	Yes	Yes
5	Enrollee	346	94.1	91.3	35.7	34.0	No	No
	Nonenrollee	709	90.8	79.4	0.1	0.0	Yes	Yes
6	Enrollee	150	96.5	97.3	80.6	100.0	No	No
	Nonenrollee	228	84.1	85.7	75.0	84.7	No	No
7	Enrollee	197	99.3	83.9	0.1	0.0	Yes	Yes
	Nonenrollee	717	86.4	76.3	0.1	0.0	Yes	Yes
8	Enrollee	71	93.3	88.5	47.7	66.2	No	No
	Nonenrollee	403	80.7	74.0	10.8	12.2	No	No

Table 2. Test results for 2 by 2 contingency tables (response status vs. age category)

Site	Enrollee/ Nonenrollee	Sample Size	Response Rate (%)		P-Value (%)		Significance at 5 %	
			Age ∃ 70	Age < 70	Chi-square	Fisher	Chi-square	Fisher
1	Enrollee	26	100.0	85.7	17.3	48.3	No	No
	Nonenrollee	383	84.4	80.3	29.8	34.6	No	No
2	Enrollee	596	94.5	93.4	59.6	58.4	No	No
	Nonenrollee	503	77.7	83.7	11.6	12.6	No	No
3	Enrollee	97	96.3	88.4	13.4	23.6	No	No
	Nonenrollee	673	81.0	78.4	40.5	44.2	No	No
4	Enrollee	186	99.1	97.4	35.9	56.8	No	No
	Nonenrollee	265	85.2	87.3	62.5	72.0	No	No
5	Enrollee	346	92.4	94.3	49.9	52.5	No	No
	Nonenrollee	725	87.8	81.7	2.3	2.5	Yes	Yes
6	Enrollee	150	97.3	94.9	46.8	60.5	No	No
	Nonenrollee	230	85.0	84.3	88.8	100.0	No	No
7	Enrollee	197	96.6	92.5	20.0	32.2	No	No
	Nonenrollee	749	83.6	77.4	3.7	3.9	Yes	Yes
8	Enrollee	71	92.9	89.7	63.4	68.3	No	No
	Nonenrollee	413	79.4	74.1	21.2	23.2	No	No